American Optometric Association
NEWS

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Seattle's lively and dynamic waterfront offers sightseeing, dining and shopping galore. Registration opens in February for the 111th Annual AOA Congress & 38th Annual AOSA Conference: Optometry's Meeting™ in Seattle at *www.optometrysmeeting.org*. *See coverage, page 7.* Photo: Seattle's Convention and Visitors Bureau.

Massive Medicare fee cut averted for 6 months

Just prior to its adjournment for 2007, Congress approved legislation that included a stop-gap plan backed by the AOA that has successfully blocked a massive 10.1 percent Medicare physician payment cut that was due to take effect on Jan. 1, 2008.

The measure, which was signed by President Bush on Dec. 29, wards off a cut in Medicare Part B reimbursements for six months and delivers ODs, MDs and other providers a marginal 0.5 percent increase in their Medicare Part B reimbursements.

However, as the AOA Washington office noted in a year-end report, optometry will again be urging Congress to address the Medicare physician reimbursement issue again during the first half of this year.

Otherwise, the planned fee cut will take effect on July 1 and could then be followed by a further reduction in January 2009.

The AOA and other health care provider groups are already preparing for a massive lobbying effort aimed at securing a long-overdue reform of the Medicare fee-setting formula and a long-term stabilization of the federal government health plan's physician reimbursements.

See Fee, page 8

Profession taking fresh look at board certification

Over the next two years, representatives of six optometric organizations hope to use the lessons learned by optometry, as well as other health care professions, to propose a model for board certification in optometry. The model would then be presented to decision-making bodies within the six organizations – in the AOA's case, the House of Delegates, for review, discussion and approval.

The Joint Board Certification Project Team includes representatives who were chosen by the leadership of their respective organizations; the American Academy of Optometry (AAO), the AOA, American Optometric Student Association (AOSA), the Association of Regulatory Boards of Optometry (ARBO), the Association of Schools and Colleges of Optometry (ASCO), and the National Board of Examiners in Optometry (NBEO). The group met in November for their third formal meeting. Another is scheduled for February.

"Of all the prescribing, doctoral-level health care professions in the United States, optometry is the only profession that does not have a board certification process available as a measure of ongoing advanced clinical competence," said AOA Vice President Randy Brooks, O.D., chair of the Joint Board Certification Project Team.

He noted that some professions have multiple certification bodies, each with different standards. For example, podiatry has three certification organizations, each with different criteria for certification.

Meanwhile, demand is building for proof that a health care professional has kept current with training and has demonstrable patient care skills.

The federal government through its Pay-for-Performance initiatives, managed care organizations with increased recordkeeping and

See Certification, page 16

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Scouting continued competence

In the 1800s, as wagon trains of enterprising pioneers moved westward, they employed scouts to show them the way.

It was the role of the scout to identify challenges and dangers ahead and find the best route through difficult terrain. Scouts would often travel several days ahead of the wagon train returning every few days to report what they found and make recommendations to the wagon train captain. Sometimes the pioneers happily received the report—beautiful country and safe passage ahead.

Sometimes the reports were not well received, with danger and hostile conditions just around the corner. Through it all, it was the scout that helped prepare the pioneers for what was ahead.

Leaders in optometric organizations can sometimes feel like scouts—scanning the future—trying to anticipate what lays ahead and reporting back to colleagues. Such is the case with continued competence.

Leaders from six organizations—the AOA, the American Optometric Student Association (AOSA), the American Academy of Optometry (AAO), the Association of Schools and Colleges of Optometry (ASCO), the Association of Regulatory Boards of Optometry (ARBO) and the National Board of Examiners in Optometry (NBEO)—met at the 2006 Academy meeting to discuss the trend toward demonstrated, continued competence by practitioners. The discussion culminated in the decision to form a Joint Board Certification Project Team (JBCPT) to develop a prototype board certification model as a means to address demonstrable, ongoing continued competence within the profession. The JBCPT was announced at SECO last year and has met twice since then.

In this issue of the *AOA News*, the JBCPT delivers the first of many reports. The process of developing a board certification process to meet the needs of the profession will take time—perhaps up to two years. Once completed, the decision to adopt a board certification process will be discussed thoroughly by the profession, and a collective decision to move forward will come from the profession.

I believe the need to develop board certification as a means to demonstrate continued competence is very real. I ask for patience by the profession as we explore this issue thoughtfully, deliberately, slowly and with the input of many.

What makes your leadership think that optometrists will be held more accountable in the years ahead? There are many reasons.

First and foremost is the public's expectation of quality care.

Today's public demands competence and will go to great lengths to find it. Right now, you can go online and see how your hospital, and in many cases your primary care physician, ranks among peers. We have moved into an age of listing "the good docs and the bad docs."

You may now make your decisions on whom to see for care, or where to have a procedure, based on this kind of public review.

Second is the concern with medical mistakes. While this may not be quite as critical for optometric practice as it is for hospital-based care, the fix for this problem is going to carry over into all types of practice—including optometry. Optometry, in general, is not prepared for the kind of scrutiny required to reduce medical errors. Peer review, credentialing and privileging, regular record review, adherence to best practices—these types of monitoring are foreign to most of us.

Dr. Alexander

Third is the adoption of electronic medical records (EMRs). The adoption of EMRs will facilitate the exchange of information by insurers, regulatory agencies and the government. While safeguards to protect privacy are being put into place, there is no question that EMRs will lead to the monitoring of the quality of care—both the care delivered by individual practitioners and by comparing practitioners to standard models of care.

Lastly, the trend toward "pay for performance" necessitates the ability of a profession to have in place a way to demonstrate ongoing competence to third-party payers. We have already started down this path with the Medicare "Pay-for-Performance" initiative. As stated in the *AOA News* article, optometry is at a disadvantage over other professions in that we do not

See President, page 18

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Study shows online CL buyers less compliant

Purchasing contact lenses online may save consumers time, but the process could cause more problems in the long run, according to a new study reported in the January issue of *Optometry: Journal of the American Optometric Association.*

The research, conducted by Joshua Fogel, Ph.D., and Chaya Zidile of Brooklyn College, found that individuals who did not purchase their contact lenses from an eye doctor, but from an online site or store, are potentially placing themselves at greater risk.

The findings indicated that online and store purchasers (consumers who get their contacts at a wholesale club or optical chain outlet) are less likely to adhere to healthy eye care practices, as recommended by their eye doctors.

Since the study results were announced, the study has been mentioned on more than 150 Web sites including Marketwire, *ScienceDaily.com* and *SmartMoney.com* and more than a dozen broadcast outlets.

To date, more than 54 million people are likely to have seen the study referenced in the days since it was released.

According to the Contact Lens Institute (CLI), more than 30 million individuals wear contact lenses. Under the Fairness to Contact Lens Consumers Act, mandating that the prescribing eye doctor provide a copy of the contact lens prescription at no charge to the patient, consumers have the option to purchase their lenses (with a valid prescription) elsewhere.

Consumers are increasingly purchasing their contact lenses online.

"We found that a pattern exists regarding the method of contact lens purchasing and following recommendations from the Food and Drug Administration (FDA)," said Dr. Fogel. "Those who bought contact lenses at their doctor's office followed a number of FDA recommendations more so than those who bought contact lenses elsewhere."

> *"Those who bought contact lenses at their doctor's office followed a number of FDA recommendations more so than those who bought contact lenses elsewhere."*

The study, which researched the purchasing and eye care behaviors of contact lens wearers, found that 86 percent of individuals who purchased their lenses from an eye doctor received a yearly comprehensive eye exam. But, only 76.5 percent of those individuals who purchased their lenses via the Internet saw an eye doctor on a routine basis.

"Frequent optometric examinations are a vital part of a contact lens wearer's preventive health care routine," said Louise Sclafani, O.D., chair of the AOA's Contact Lens and Cornea Section.

"Having one's eye health and vision examined on a regular, timely basis is important to maintaining overall health and can even lead to early detection of various diseases."

According to the study, 35 percent of online purchasers did not check that the prescription was correct.

One of the largest discrepancies found between in-office and out-of-office contact lens purchases was seen in the number of individuals who saw an eye doctor for a follow-up appointment to ensure the proper fit of their lenses.

Fifty-seven percent of individuals who purchased their lenses from an eye doctor went in for a follow-up appointment; as compared to only 29 percent of online purchasers.

The research also indicated that the majority of consumers feel more confident purchasing their contact lenses from a familiar and reliable place such as their eye doctor or store rather than through the Internet.

In fact, 89 percent and 91 percent of respondents respectively said they felt confident purchasing contact lenses from their familiar, reliable eye doctor or store.

That number decreased to 77 percent when surveying individuals who made a purchase via the Internet.

"Although buying contacts online can be more cost-effective and convenient, we strongly urge patients to understand that there are risks involved to wearing contact lenses," said Dr. Sclafani. "Because of this, it's necessary that patients visit their eye doctor on a regular basis and communicate any recent visual changes and discomfort experienced as a result of contact lens wear."

The study was conducted by Dr. Fogel and Zidile of Brooklyn College. Using a convenience sample of 151 students from the university, participants completed a questionnaire on topics related to Internet use and contact lenses, time pressure,

FDA recommendations for purchasing contact lenses online, demographic items, and other items about beliefs and attitudes toward the Internet.

There were no specific exclusion criteria other than not wearing contact lenses.

FTC halts unlawful contact lens sales by 2 retailers

Two marketers of non-corrective, cosmetic contact lenses have agreed to settle Federal Trade Commission (FTC) charges that they violated federal law by selling lenses without prescriptions.

According to FTC complaints, BeWild, Inc. along with its president, Brian Cohen, and Pretty Eyes, LLC along with its owner, Christianne McNulty, have violated the FTC's Contact Lens Rule and the FTC act by selling non-corrective contact lenses on their Web sites, *www.bewild.com* and *www.prettyeyes.org*, without obtaining consumers' prescriptions or verifying the prescriptions with the prescribers, and failing to keep proper records of prescriptions and verifications.

As *AOA News* went to press, no contact lenses were offered for sale at BeWild's site, and *prettyeyes.org* had been vacated.

BeWild and Cohen also are charged with violating the Contact Lens Rule by representing that their contact lenses can be obtained without a prescription.

Under the proposed settlements, the defendants are prohibited from selling contact lenses without obtaining prescriptions or verifying the prescriptions directly from the prescribers, from failing to maintain records of prescriptions and verifications, and from violating the Contact Lens Rule.

BeWild and Cohen also are prohibited from misrepresenting that contact lenses may be obtained without a prescription and will pay a civil penalty of $11,000.

The FTC is waiving all but $2,500 of a $25,000 civil penalty ordered for Pretty Eyes and McNulty, based on their financial condition.

The FTC charged the two retailers under terms of the 2003 Fairness to Contact Lens Consumers Act (FCLCA), which imposed new prescription release and verification requirements on prescribers and sellers of contact lenses.

The settlements mark the latest in a series of actions by the FTC in recent months to curb illegal contact lens sales by retailers. On Oct. 12, FTC staff sent warning letters to 15 sellers of non-corrective, cosmetic contact lenses who appeared to be providing contact lenses to consumers without valid prescriptions.

The FTC notes that the consent decrees are for settlement purposes only and do not constitute an admission by the defendants of a law violation. A consent decree is subject to court approval but has the force of law when signed by the judge.

The AOA Advocacy Group urges optometrists to report violation of the federal Contact Lens Rule to the FTC. Complaints can be filed through the FTC Web site (*www.ftc.gov/ftc/complaint.shtm*) or by calling 877-382-4357. The AOA also requests optometrists forward copies of any complaints to the AOA Washington office (at *FTCcomplaint @aoa.org*).

"The FTC Contact Lens Rule: A common sense approach to compliance," a detailed look at the rule compiled by the AOA Office of Counsel in light of recent enforcement actions by the FTC, appears in the February edition of *Optometry: Journal of the American Optometric Association*.

AOA members can find additional information on federal contact lens laws as well as links to AOA Washington office and the FTC on the AOA Web site FCLCA page (*www.aoa.org/x4843.xml*).

New year again brings coding changes

Administrators for the billing code systems used by public and private health plans often implement changes around the beginning of each year, and 2008 is no exception.

A number of coding changes this year are applicable to optometry. The American Medical Association's (AMA) 2008 Physician's Current Procedural Terminology (CPT) code set provides new CPT Category 1 Evaluation and Management (E&M) and procedure codes for "non-face-to-face" physician services such as telephone consultations and online medical evaluations.

Also included in the 2008 CPT Category I codes are new E&M codes for nursing facility services, new and revised eye and ocular adnexa surgical codes, and a new code for ocular photoscreening.

The 2008 CPT code set also includes several new CPT Category II codes for eye care. CPT Category II provides supplementary tracking codes that can be used for performance measures in programs such as Medicare's Physician Quality Reporting Initiative.

The 2008 code also provides two CPT Category III codes that may be applicable to optometry. CPT Category III provides temporary codes for emerging technology, services and procedures. The codes are used to describe products or services that are the subject of clinical trials.

The latest regularly scheduled updating of the International Classification of Diseases, Ninth Revision (ICD-9) and the U.S. Department of Health and Human Services' Health Care Procedures Coding System, (HCPCS) codes have also resulted in several changes in the coding used to report eye or vision care services.

The AOA Coding Subcommittee has outlined major coding changes relevant to optometric practice in this issue of *AOA News*.

The 2008 edition of the AOA's Codes for Optometry, the only comprehensive coding guide developed specifically for optometric practices, provides a complete listing of all codes relevant to eye and vision care.

Codes for Optometry can be purchased through the AOA Order Department by calling 800-262-2210, faxing orders to 314-991-4101 (Attn: Order Department), logging on to the AOA Web site Order Department page (*www.aoa.org/x4795.xml*) or e-mailing *orders@aoa.org*.

AOA outlines changed CPT Codes for 2008

Evaluation and Management: Nursing facility services and initial nursing facility care

New or Established Patient Revised CPT Codes

99304: Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components; **added** "Physicians typically spend 25 minutes with the patient and/or family or caregiver."

99305: Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components; **added** "Physicians typically spend 35 minutes with the patient and/or family or caregiver."

99306: Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components; **added** "Physicians typically spend 45 minutes with the patient and/or family or caregiver."

Subsequent nursing facility care

99307: Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components; **added** "Physicians typically spend 10 minutes with the patient and / or family or caregiver."

99308: Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components; **added** "Physicians typically spend 15 minutes with the patient and / or family or caregiver."

99309: Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components; **added** "Physicians typically spend 25 minutes with the patient and / or family or caregiver."

99310: Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components; **added** "Physicians typically spend 35 minutes with the patient and / or family or caregiver."

Other nursing facility services

99318: Evaluation and management of a patient involving an annual nursing facility assessment, which requires these three key components; "Physicians typically spend 30 minutes with the patient and / or family or caregiver."

Non-face-to-face physician services

Telephone Services

Telephone services are non-face-to-face evaluation and management (E/M) services provided by a physician to a patient using the telephone.

These codes are used to report episodes of care by the physician initiated by an established patient or guardian of an established patient. If the telephone service ends with a decision to see the patient within 24 hours or next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the preservice work of the subsequent E/M service, procedure, and visit. Likewise, if the telephone call refers to an E/M service performed and reported by the physician within the previous seven days (either physician requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) are considered part of that previous E/M service or procedure. (Do not report 99441-99443 if reporting 99441-99444 performed in the previous seven days.)

New CPT Codes

99441: Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

99442: 11-20 minutes of medical discussion

99443: 21-30 minutes of medical discussion

Online medical evaluation

An online electronic medical evaluation is a non-face-to-face evaluation and management E/M service by a physician to a patient using Internet resources in a response to a patient's online inquiry. Reportable services involve the physician's personal timely response to the patient's inquiry and must involve permanent storage (electronic or hard copy) of the encounter.

The service is reported only once for the same episode of care during a seven day period, although multiple physicians could report their exchange with the same patient. If the online medical evaluation refers to an E/M service previously performed and reported by the physician within the previous seven days (either physician requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) are considered covered by the previous E/M service or procedure. A reportable service encompasses the sum of communication (e.g., related telephone calls, prescription provisions, laboratory orders) pertaining to the online patient encounter.

See Codes, page 6

Codes

from page 5

99444: Online evaluation and management service provided by a physician to an established patient, guardian, or health care provider not originating from a related E/M service provided within the previous seven days, using the Internet or similar electronic communications network.

Surgery/ eye and ocular adnexa

New surgical codes
67041: With removal of preretinal cellular membrane (eg, macular pucker).
67042: With removal of internal limiting membrane or retina (e.g., for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (ie, air, gas, or silicone oil) and laser photocoagulation.
67043: With removal of subretinal membrane (eg, chorodial neovascularization), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil) and laser photocoagulation.
67113: Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, may include air, gas or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and / or removal of lens.
67229: Preterm infant (less than 37 weeks gestation at birth), performed from birth up to 1 year of age (eg, retinopathy of prematurity), photocoagulation or cryotherapy.
68816: With transluminal balloon catheter dilation

Revised surgical CPT codes:
67227: Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), one or more sessions, cryotherapy, diathermy.
67228: Treatment of extensive or progressive retinopathy, one or more sessions, cryotherapy, diathermy.

Medicine Section: Non-face-to-face nonphysician services

Revised Descriptor
92135: Scanning computerized ophthalmic diagnostic imaging, posterior segment, (eg, scanning laser) with interpretation and report, unilateral.

Non-face-to-face nonphysician services

Telephone Service
Telephone services are non-face-to-face assessment and management services provided by a qualified health care professional to a patient using the telephone.

These codes are used to report episodes of care by the qualified health care professional initiated by an established patient or guardian of an established patient. If the telephone service ends with a decision to see the patient within 24 hours or the next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the preservice work of the subsequent assessment and management service, procedure and visit.

Likewise, if the telephone call refers to a service performed and reported by the qualified health care professional within the previous seven days (either qualified health care professional requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) are considered part of that previous service or procedure. (Do not report 98966-98969 if reporting 98966-98969 performed in the previous seven days.)

New:
98966: Telephone assessment and management service provided by qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days not leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
98967: 11-20 minutes of medical discussion
98968: 21-30 minutes of medical discussion

Online medical evaluation:

98969: Online assessment and management service provided by a qualified nonphysician health care professional to an established patient, guardian, or health care provider not originating from a related assessment and management service provided within the previous seven days, using the Internet or similar electronic communications network.

Other services and procedures:

New:
99174: Ocular photoscreening with interpretation and report, bilateral.

Category II Codes
(The following Category II codes were released in October 2006 online but did not appear in the AMA's-CPT book until January 2008.)

Newly listed CPT codes
1055F: Visual function status assessed
2019F: Dilated macular exam performed, including documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity.
2020F: Dilated fundus evaluation performed within six months prior to cataract surgery.
2021F: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy.
2027F: Optic nerve head evaluation performed.
3073F: Pre-surgical (cataract) axial length, corneal power measurement and method of intraocular lens power calculation documented within six months prior to surgery.
5010F: Findings of dilated macular or fundus exam communicated to the physician managing the diabetes care.
Category III CPT Codes
(The following Category III codes were released July 1, 2007, and implemented Jan. 1, 2008.)
0186T: Suprachoroidal delivery of pharmacologic agent (does not include supply of medication).
0187T: Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral.

ICD-9 update brings new codes

This year's regularly scheduled updating of the International Classification of Diseases, Ninth Revision (ICD-9) codes has resulted in a several changes in coding used to report eye or vision care services. The coding changes took effect Oct. 1. They include:

- A new code modifier V49.85 (Dual sensory impairment, Blindness with deafness) to be used to indicate combined visual-hearing impairment with the hearing impairment (389.00-389.9) and visual impairment (369.00-369.9) codes, and
- A number of changes in the 364.8 and 364.9 codes requiring greater specificity in the reporting of conditions of the iris. A diagnosis code for intraoperative floppy iris syndrome (IFIS), 364.81, has been added.

In addition, there are some new V codes—such as V68.01 - Disability examination and V68.09 - Other issue of medical certificates—which optometrists may need to know about in light of their disability determination authority under Social Security.

The ICD-9-CM codes are updated annually as stated in the Medicare Claims Processing Manual, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service).

The CMS reminds health care providers that ICD-9-CM codes are required for all professional claims (including those from physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologists, ambulatory surgical centers), and for all institutional claims.

MM5643 can be viewed on the CMS Web site at *www.cms.hhs.gov/MLNMattersArticles/downloads/MM5643.pdf* or CMS Change Request CR 5643 at *http://www.cms.hhs.gov/Transmittals/downloads/R1269CP.pdf.*

All new, revised, and discontinued ICD-9-CM diagnosis codes on the CMS Web site can be viewed at *www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/ 07_summarytables.asp#TopOfPage* or at the National Center for Health Statistics (NCHS) Web site at *www.cdc.gov/nchs/icd9.htm*.

‘The Pursuit of Happyness’ author to speak at Optometry’s Meeting™

Christopher Gardner

Christopher Gardner, the author of “The Pursuit of Happyness,” will be the keynote speaker at the Opening General Session for the 2008 Optometry’s Meeting™. Sponsored by Essilor, the Opening General Session will be Thursday, June 26 from 8 a.m. to 9:30 a.m.

In “The Pursuit of Happyness,” Gardner chronicled his long, painful, yet ultimately rewarding, journey from inner-city Milwaukee to the pinnacle of Wall Street.

Gardner is also the inspiration for the acclaimed movie “The Pursuit of Happyness,” for which Will Smith, starring as Gardner, received Golden Globe, Screen Actors Guild, and Academy Award nominations.

Gardner’s autobiography was a *New York Times* and *Washington Post* No. 1 best-seller.

In the book, Gardner solidly depicted growing up black and male in late 20th-century urban America.

Surmounting acute obstacles throughout his life, Gardner is an avid motivational speaker, addressing the keys to self-empowerment, beating odds and breaking negative cycles.

Gardner is the owner and CEO of Christopher Gardner International Holdings with offices in New York, Chicago, and San Francisco.

Gardner is also a passionate philanthropist committed to many charitable organizations.

Always hard-working and tenacious, a series of circumstances in the early 1980s left Gardner homeless in San Francisco and the sole guardian of his toddler son.

Unwilling to give up Chris Jr. or his dream of financial independence, Gardner started at the bottom. Without connections or a college degree, he earned a spot in the Dean Witter Reynolds training program.

Often spending his nights in a church shelter or the bathroom at a Bay Area Rapid Transit station in Oakland, Gardner was the sole trainee offered a job at Dean Witter Reynolds in 1981.

He spent 1983 to 1987 at Bear Stearns & Co., where he became a top earner.

In 1987, he founded the brokerage firm Gardner Rich & Co. in Chicago.

Gardner’s remarkable story of struggle, faith, entrepreneurialism, and fatherly devotion has catapulted him beyond the notoriety he has found on Wall Street.

Gardner has been featured on the “Evening News with Dan Rather,” “20/20,” the “Oprah Winfrey Show,” the “Today Show,” “The View,” “Entertainment Tonight,” CNN, CNBC, and Fox as well as being the subject of profiles in numerous media including *People*, *USA Today*, Associated Press, *The New York Times*, *Fortune*, *Jet*, *Reader’s Digest*, *Trader Monthly*, *Chicago Tribune*, *San Francisco Chronicle*, *The New York Post* and the *Milwaukee Journal Sentinel*. Gardner lives in Chicago and New York.

Optometry’s Meeting™ registration opens in February. For more information, visit *www.optometrys-meeting.org.*

Attractions for all beckon in Seattle

The 2008 Optometry’s Meeting™ will be hosted at the Washington State Convention and Trade Center in Seattle June 25-29.

The Emerald City is home to more than just its reputation for rain—it’s filled with the myriad delights of the Pacific Northwest.

One of Seattle’s top sights is the Space Needle where visitors can observe Seattle’s multifaceted geography from 520 feet. The needle was originally built for the 1962 World’s Fair.

Another way to enjoy Seattle’s unique geography is by ferry ride. Observers can glimpse spectacular views of the city, Cascade and Olympic Mountains and the shoreline.

The Pike Place Market is another well-known attraction. Filled with fish, flowers and fun, the market has over 200 businesses to stroll through and enjoy.

Whale watching is another popular activity. Visitors can observe the orcas who call the Puget Sound their home.

Optometry’s Meeting™ attendees can also take Bill Speidel’s Underground Tour and explore the ruins of the city of Seattle before it was engulfed in flames in 1889.

The city is also home to the Seattle Public Library. Book lovers and architecture buffs alike will be drawn to this award-winning building made of steel and glass. Visitors can return to the past at Tillicum Village. They can take a tour of a Native American island village and learn about the ways of the Northwest’s original residents. Seattle is filled with outdoor adventures.

The area offers a wealth of outdoor activities for nature enthusiasts including hiking, whitewater rafting, cycling, scuba diving, golfing, camping, mountain biking and sea kayaking.

Of course, a visit to Seattle would not be complete without drinking some coffee.

Optometry’s Meeting™ attendees can grab a cup of java at one of the capital of coffee’s 628 coffee shops before focusing on the more than 200 hours of world class education, exhibit hall displays, House of Delegate business, social events, and networking opportunities.

Registration opens in February. Visit *www.optometrys-meeting.org* for more information.

The beautiful Seattle skyline and Puget Sound seen from Bainbridge Island at night. Photo: Tim Thompson

Fees,

from page 1

The U.S. Centers for Medicare & Medicaid Services (CMS) updates Medicare physician reimbursement with the start of each calendar year.

On Nov. 1, the CMS announced plans to cut reimbursement levels for 2008, marking the seventh time in as many years the agency has proposed cuts in the Medicare physician fee schedule.

At the urging of the AOA and other groups monitoring the issue in Washington, D.C., Congress has intervened to safeguard health care practitioners and patients from these devastating reductions.

This year's planned Medicare physician reimbursement cut was postponed under terms of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (S. 2499), which was passed by the Senate Dec. 18, and by the House of Representatives a day later.

The legislation was introduced in the House by Rep. Charles Rangel (D-N.Y.) and Rep. Jim McCrery (R-La.) and in the Senate by Sen. Max Baucus (D-Mont.) and Sen. Charles Grassley (R-Iowa).

In addition to protecting Medicare physician reimbursement over the first half of this year, the measure extends funding for the State Children's Health Insurance Program (SCHIP), Medicare quality reporting programs such as the Physician Quality Reporting Initiative (PQRI), Medicare Advantage and other Medicare and Medicaid programs.

AOA Advocacy Group Director Jon Hymes credited the successful inclusion of a temporary Medicare fee-fix in the bill to efforts by Sen. Baucus and Sen. Grassley as well as Rep. Rangel and other key leaders in Congress. Sen. Grassley and Sen. Rangel are recipients of the AOA's Health Care Leadership Award.

The congressional action came after several weeks of effective grassroots lobbying by AOA Keypersons and active AOA members, Hymes said.

Hymes also pointed to very effective Capitol Hill testimony on the impact of Medicare physician payments cuts on optometry that was provided on Nov. 8 by John Whitlow, O.D., president of the Georgia Optometric Association, before a U.S. House subcommittee hearing.

Dr. Whitlow was the only non-MD selected to testify before the panel.

Lawmakers also appear to have been prompted to action by numerous personal calls, letters and e-mails to legislators from health care providers, Hymes said. Many of those e-mails were sent through services such as the AOA's online Legislative Action Center, he said.

Lawmakers will officially reconvene for the second session of the 110th Congress on Jan. 22.

The AOA Advocacy Group's 2008 Congressional Conference, organized optometry's major annual Capitol Hill lobby effort, is scheduled April 6-10, just as lawmakers are likely to be considering Medicare physician reimbursement legislation.

Because of the late change in the Medicare fee schedule, the CMS has announced that it will allow physicians an additional 45 days to decide whether to participate in the Medicare program for 2008.

Health care practitioners now have until Feb. 15 to determine whether to participate or not.

At the urging of the AOA and other groups, Congress has intervened to safeguard health care practitioners and patients from these devastating reductions.

Flawed formula continues to erode physician pay

Both the Centers for Medicare and Medicaid Services (CMS) and provider groups blame the string of proposed Medicare fee cuts over recent years on an economic indicator known as the Sustainable Growth Rate (SGR). The SGR is among the factors considered in a complex formula that under federal law is used to set Medicare physician reimbursements. The indicator ties Medicare fee levels to the overall performance of the U.S. economy.

Left unchanged, the formula will continue to result in fee reductions each year, according to speakers at last year's AOA Congressional Conference. The formula will reduce physician reimbursements by around one-third over the next few years alone, AOA Federal Relations Committee Chair Michele Haranin, O.D., told the conference.

The AOA and other provider groups have made a top priority of changing the fee-setting formula to permanently stabilize Medicare physician reimbursement. The Medicare Payment Advisory Commission, the body established by Congress to make recommendations on Medicare payment issues, has recommended replacing the SGR with another cost indicator.

However, many in Congress reportedly want to tie any fee stabilization measures to quality enhancement efforts such as pay-for-performance programs. This year's short-term fee fix in the just-passed legislation was coupled to an extension of the physician quality reporting system, AOA Advocacy Group Director Jon Hymes noted.

With physicians facing the prospect of a fee cut in just six months, provider groups will have to "re-double" their efforts this year to both ensure the short-term stability of Medicare reimbursement and, they hope, achieve a "permanent fix" for the Medicare fee formula, Hymes said.

"The AOA and other health provider groups pushed hard in 2007 for Congress and the president to fix the flawed Medicare reimbursement formula," Hymes said. "However, there's no consensus as yet on any one solution that will work for the long-term. It now becomes critically important for lawmakers, the White House, and provider organizations to continue to work toward a fair and reasonable reimbursement formula that protects doctors and patients."

New HCPCS IOL codes

Updates to the U.S. Department of Health and Human Services' Health Care Procedures Coding System (HCPCS) for 2008 include two changes pertinent to the practice of eye or vision care. Administrators have added two new material codes:

V2787 – Astigmatism Correcting Function of Intraocular Lens.

V2788 – Presbyopia Correcting Function of Intraocular Lens.

The HHS maintains the HCPCS to describe services and supplies not covered under the CPT codes.

Call for posters open

The AOA is inviting participation in the Clinical and Scientific Poster Session at the 111th Annual AOA Congress & 38th Annual AOSA Conference: Optometry's Meeting™.

The program creates a national forum for clinicians, students, and faculty to communicate interesting cases and unique research to their colleagues.

The poster preview session will be held Friday, June 27, 2008, and the interactive session offering continuing education credit will be Saturday, June 28, 2008, from 11 a.m. to 2 p.m. at the Washington State Convention and Trade Center.

Poster abstracts must be submitted electronically and must be received by Feb. 6, 2008. For details and an electronic submission form, log on to *www.optometrysmeeting.org* and click on the Call for Posters icon. For more information, contact Stacy Smith at (314) 983-4254 or at *sasmith@aoa.org*.

Ohio expands orals authority for ODs

Ohio Gov. Ted Strickland (D) signed H.B. 149, expanding the oral prescriptive authority of optometrists in the state and adding the use of injectables to treat anaphylaxis and use of blood sugar testing devices, on Dec. 21.

The bill also exempts students from optometry schools in other states participating in a training program in Ohio from licensure and requires the Ohio Optical Dispensers Board to regulate the dispensing of plano contact lenses.

"The passage of our scope bill was a thorough and deliberate process," said Cheryl Archer, O.D., immediate past president of the Ohio Optometric Association (OOA). "Numerous leaders in the association worked to make this happen."

The bill, sponsored by State Reps. David Daniels (R) and Fred Strahorn (D), amended the definition of the practice of optometry to repeal the limitation to treatment of the "anterior segment."

In addition, the definition was amended to include the use of a commercially available glucose-monitoring device.

The previous formulary of specific diagnostic drugs available for use or application was repealed.

> *"Ohio is proud of our new scope of practice bill and considers it a significant win for our patients. The new aspects of Ohio scope of practice will prove to be cost-effective and assure the highest quality of primary eye care."*

The previous formulary of specific oral drugs for use or prescription was repealed, and all appropriate oral drugs in the following classes are now authorized:

- anti-infectives, including antibiotics, antivirals, antimicrobials, and antifungals;
- anti-allergy agents;
- anti-glaucoma agents;
- analgesics, including analgesic drugs that are available without a prescription, analgesic drugs or dangerous drugs that require a prescription but are not controlled substances, and Schedule III controlled substances that are approved by the state board of optometry in rules;
- anti-inflammatories (excluding all oral steroids except methylpredisolone); and
- any other oral drug approved by the board of optometry (in consultation with the board of pharmacy) that is approved or exempt from approval or certified or exempt from certification by the Federal Food and Drug Administration for ophthalmic purposes.

Oral methylpredisolone may be prescribed if all of the following conditions are met:

- the drug is prescribed for use in allergy cases;
- the drug is prescribed for use by an individual who is 18 years of age or older;
- the drug is prescribed on the basis of an individual's particular episode of illness; and
- the drug is prescribed in an amount that does not exceed the amount packaged for a single course of therapy.

The bill gave specific authority for optometrists to dispense vision correction devices, including, but not limited to, contact lenses that have vision correction as their primary purpose but also combine with that purpose the delivery of a drug through the device, if the drug delivered by the device would otherwise be a topical ocular pharmaceutical agent or oral therapeutic pharmaceutical agent.

The bill sets continuing education hours required for license renewal to 25 hours (the law previously allowed the board of optometry to set the required hours between six and 25 hours). The 25-hour requirement includes at least 10 hours in pharmacology (up from the previous five hours).

"Ohio is proud of our new scope of practice bill and considers it a significant win for our patients," said Karen Riccio, O.D., OOA president. "The new aspects of Ohio scope of practice will prove to be cost-effective and assure the highest quality of primary eye care."

The bill also requires contact lens prescriptions to include all information specified by the federal Fairness to Contact Lens Consumers Act.

The ophthalmic dispenser law requiring a prescription for the dispensing of contact lenses was amended to include in the definition of a contact lens: "zero-powered plano contact lenses, cosmetic contact lenses, performance-enhancing contact lenses, and any other contact devices determined by the optical dispensers board to be contact lenses."

SCCO selects Alexander as president

The Southern California College of Optometry (SCCO) selected AOA President Kevin Alexander, O.D., Ph.D., as its president, effective July 1.

Dr. Alexander will replace Lesley Walls, O.D., M.D., who is retiring after 11 years in the position.

Dr. Alexander is currently the dean of the Michigan College of Optometry at Ferris State University.

"Experience and leadership in the areas of academe and the optometric profession are key assets that factored into the selection of Dr. Kevin Alexander as the next president of the Southern California College of Optometry," said Charles Munson, chair of the SCCO Board of Trustees. "His experience as a dean at an optometric college and his years of leadership within organized optometry make him an excellent choice to work with our students, faculty and alumni in advancing the mission of SCCO. He and his wife, Carol, also an optometrist, will be wonderful additions to our great team."

Dr. Alexander graduated from The Ohio State University College of Optometry, where he later held a faculty position.

He has practiced in private and group settings, published scientific papers and lectured for continuing education.

Dr. Alexander has served on numerous AOA committees and chaired the Optometry 2020 Summits.

His many awards include The Ohio State University College of Optometry H. Ward Ewalt Medal for Distinguished Service (2007), the Michigan Optometric Association Keyperson of the Year (2002), Distinguished Practitioner of the National Academies of Practice (2000), the Outstanding Service Award from the Ohio Optometric Association (OOA) (1992 and 1998) and the OOA Warren Morris Optometrist of the Year (1989).

"I am thrilled to have been named the president of the Southern California College of Optometry and eager to join the college family as we take our institution to the next level of excellence," said Dr. Alexander.

"I look forward to working with the students, faculty and alumni in building upon the college's strong history of providing an excellent educational program, exceptional patient care and outstanding leadership for the optometric profession," he added.

AOA resources offer detailed guidance on PQRI

Health care providers taking part in Medicare's 2008 Physician Quality Reporting Initiative (PQRI) can earn a bonus of approximately 1.5 percent of their total Medicare reimbursement for the year, according to the U.S. Centers for Medicare & Medicaid Services (CMS).

However, health care practitioners should also be aware that the CMS has made a number of changes in the PQRI program this year, according to the AOA Coding Subcommittee.

Program rules issued by the CMS Nov. 27 in the *Federal Register* expand the PQRI reporting period to a full year (Jan. 1 – Dec. 31) in 2008, eliminate several eye care measures that were reportable under the 2007 program, and add several new measures to the program.

Additional guidance issued by CMS in late December clarified coding and reporting specification for a number of measures.

The AOA, CMS and other health provider organizations are now offering new or revised resources designed to assist practitioners with successful participation in the 2008 PQRI.

PQRI Measures 2008, a guide to PQRI participation developed specifically for optometrists by the AOA Coding Subcommittee, outlines all 11 PQRI eye care, administrative and screening or counseling measures applicable to optometric practice this year, along with detailed reporting instructions. The guide appears in this issue of *AOA News.*

AOA PQRI Web page

The AOA Web site's PQRI page has been updated to reflect changes in the 2008 PQRI program pertinent to optometry. The Web page includes:

- An introduction to the PQRI
- Changes in the measures that optometrists can report under the 2008 PQRI program
- The latest PQRI news and alerts from the CMS
- A complete "How to Code for Eye Care Measures" section including:
  - PQRI coding definitions
  - Tools and resources
  - A PQRI summary chart
  - Filing specifications and examples
  - The AOA's and CMS's PQRI PowerPoint Presentations
  - An explanation of PQRI bonus incentive payment
  - The CMS Coding for Quality Handbook

The CMS's new 2008 *PQRI Coding for Quality Handbook*, released in late December, outlines coding and reporting principles and describes successful reporting for each measure. The handbook is available through the CMS Web site PQRI page *(www.cms.hhs.gov/pqri*).

CMS PQRI measure specifications notes

The CMS 2008 Measure Specifications Release Notes, also made available in December, describe recent changes to measure specifications due to recent technical corrections. The notes are also available on the CMS Web site PQRI page (*www.cms.hhs.gov/pqri*).

For practitioners seeking even more detailed guidance, the American Medical Association's (AMA) PQRI Participation Tools are designed to help physicians and other eligible professionals identify measures relevant to their practice and facilitate the data collection required to report clinical performance data.

Information is available for each of the 119 PQRI quality measures. The tools are now available online at ww*w.ama-assn.org/go/toolsMedicarePQRI.*

All of the listed resources can be accessed through the AOA Web site PQRI page at *http://www.cms.hhs.gov/pqri.xml.*

January is Glaucoma Awareness Month

The U.S. Centers for Medicare & Medicaid Services (CMS) is asking optometrists to help make patients aware of Medicare coverage for glaucoma-related services in conjunction with the January observance of National Glaucoma Awareness Month.

As part of its Optometry Awareness and Public Affairs campaign, the AOA Communications Group, through the public relations firm of Hill & Knowlton, this month issued a national press release to help raise public awareness regarding the eye disease.

Approximately 3 million Americans have glaucoma, the CMS notes. However, because the disease often progresses in the initial stages with no symptoms, it is estimated that up to half do not know they have it.

Medicare Coverage

Medicare provides coverage of an annual glaucoma screening for beneficiaries in at least one of the following high-risk groups:

- Individuals with diabetes mellitus;
- Individuals with a family history of glaucoma;
- Blacks age 50 and older; and
- Hispanics age 65 and older.

A covered glaucoma screening includes:

- A dilated eye examination with an intraocular pressure (IOP) measurement; and
- A direct ophthalmoscopy examination or a slit-lamp biomicroscopic examination.

What practitioners can do

Unfortunately, many Medicare patients remain unaware that the government health program covers glaucoma-related services.

"CMS needs your help to ensure that all eligible people with Medicare take full advantage of the annual glaucoma screening benefit," the agency emphasized in a statement to eye care providers this month.

To help health care professionals and their staffs understand coverage, coding, billing, and reimbursement for preventive services and screenings covered by Medicare, the CMS offers the Medicare Learning Network (MLN) Preventive Services Educational Products Web Page that provides descriptions and ordering information for all provider specific educational products related to preventive services.

The Web page is *www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp.*

2008 PQRI measures: What ODs need to know

By Rebecca H. Wartmann, O.D.
AOA Coding Subcommittee

The year of 2008 brings changes to the Physician Quality Reporting Initiative (PQRI) measures that optometrists can use. Several of the measures from the 2007 PQRI program have been withdrawn and new measures have been added. This article will review the origins for the PQRI measures, the reporting to expect from the 2007 initiative, and the 2008 measures as they are currently published. Please refer to the AOA Web site for any updates that might occur and all the tools practitioners may need for the 2008 PQRI reporting period. For the sake of accuracy, the terminology in this article, whenever possible, was taken directly from the CMS regulation.

Background

The PQRI was created as a part of the Tax Relief and Healthcare Act of 2006 that provides the statutory authority for the quality improvement program. PQRI reporting will focus attention on quality of care rather than resources utilized. The basis for this initiative is evidence-based measures developed by professionals and endorsed by national consensus groups such as the National Quality Forum (NQF) and the AQA (formerly the Ambulatory Care Quality Alliance). When the approved quality measurements are reported frequently enough, the Medicare provider will be rewarded financially. The hope is that PQRI will result in improved patient care. Eventually, it is expected that Medicare will move to a true "pay-for-performance" system.

2007 report results

The reports of the 2007 PQRI analysis and bonus payments will be available in June 2008. No interim reports were made available. This means that no one will know how they performed in 2007 until halfway through the 2008 reporting period.

Several reporting challenges were found during the 2007 reporting periods.

These challenges included National Provider Identification (NPI) numbers being stripped off claims, inappropriate denials for provider types, and clearinghouses stripping PQRI CPT II codes from claims. At this time, no one knows how widespread these problems were or the ultimate impact on the success of reporting measures and earning bonuses.

The reports of the 2007 PQRI results will be sent to the holder of the Tax Identification Number (TIN) but broken down by NPI number. The report results will not be publicly available. Each report will give details of the number of claims eligible that were filed compared to the number of eligible claims that were properly filed with the appropriate PQRI reporting codes. Many other statistical details will be listed on each report.

2008 PQRI measures

Participation in the 2008 PQRI program remains voluntary, and the bonus amount will still be approximately 1.5 percent of all allowable Medicare claims, including the –TC components of procedures. While a 1.5 percent bonus incentive may not be significant in terms of monetary reward, the result from a large number of optometrists participating in this program will yield positive recognition of optometry within the CMS.

There are 119 measures available for reporting in 2008.

Retired measures

15 measures were retired in 2008, including the following eye care measures:

- Measure #13: 4007F ARMD - AREDS Prescribed/Recommended
- Measure #15: 1055F Cataracts - Visual Functional Status Assessment
- Measure #16: 3073F Cataracts - Pre-surgical Measurements
- Measure #17: 2020F Cataracts - Pre-surgical Dilated Fundus Evaluation

Edited measures

The remaining 2007 measures have had some edits made. Please see the details of the measures later in the article for those changes. The remaining available measures are:

- Measure #12: 2027F Primary Open Angle Glaucoma - Optic Nerve Evaluation
- Measure #14: 2019F ARMD - Dilated Macular Examination
- Measure # 18: 2021F Diabetic Retinopathy Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
- Measure # 19: 5010F with G8397 OR G8398 Diabetic Retinopathy Communication with Physician Managing Ongoing Diabetes Care
- In addition, a new measure is available relating to eye care. Measure #117: 2022F, 2024F, 2026F, OR 3072F Dilated Eye Exam in Diabetic Patient

Additional measures

Additional measures that may be available for use by eye care professionals (and others) are:

- Measure #114: 1000F AND 1034F/1035F/1036F - Inquiry Regarding Tobacco Use
- Measure #115: G8456&G8402 OR G8456&G8457 OR G8455&G8403 - Advising Smokers to Quit
- Measure #124: G8447, G8448, OR G8449 HIT - Adoption/Use of Health Information Technology (HIT) (Electronic Health Records)
- Measure #125: G8443, G 8445. OR G8446 HIT - Adoption/Use of e-Prescribing
- Measure #128: G8422, G8421, OR G8419 - Universal Weight Screening and Follow-Up
- Measure #129: G8423, G8426, G8424, OR G8425 - Universal Influenza Vaccine Screening and Counseling

*Use of appropriate G-code depends on specification guidance

Thus, 11 measures are potentially available for use by eye care professionals. The guidelines still state a practitioner must report at least three measures on 80 percent of the reportable cases to be eligible for the bonus payment.

See Quality, page 12

Bonuses

Bonus payments will be made in a one-time lump sum payment in mid-2009, for PQRI reporting in 2008. The bonus payment will be made to the holder of the Tax Identification Number (TIN) broken down by NPI number.

The maximum bonus will be 1.5 percent of ALL Medicare allowable charges filed during the reporting period, including the –TC component of any diagnostic services.

In some instances, a cap may be applied to the bonus. This cap would be applied when an individual provider only has a small number of claims in which measures could apply compared to the total number of claims that provider actually filed.

Because there are five eye care-specific measures and six additional measures available for reporting, most optometrists will not be impacted by the bonus payment cap.

Details of how this cap is calculated can be found at *www.cms.hhs.gov/PQRI* or *www.aoa.org/PQRI.xml*.

Reporting quality measures – filing specifics

Notes

All the applicable measures are detailed in this article. Frequent review of the CMS guidance is strongly recommended and encouraged.

The 2008 reporting period is Jan. 1, 2008 - Dec. 31, 2008. Note that practitioners may be required to report measures more than once within the reporting period because the reporting period covers an entire 12 months. As in 2007, the AOA recommendation is that the measures be reported in every instance to ensure that an optometrist meets all the minimum coding guidelines to earn the bonus payments.

Also note that several of these measures are using G codes for the reporting in addition to the more familiar CPT II codes. G codes are used when there is not a CPT II code to adequately describe the measure. When a G code is used, the modifiers 1P, 2P, 3P and 8P are not used. Instead, a different G code is used to describe each coding situation.

The AOA Web site will have all the tools needed to properly utilize all the 2008 PQRI measures. Please visit this site frequently. Updates will be posted as they become available.

Measure #12: 2027F
Primary Open Angle Glaucoma - Optic Nerve Evaluation

This measure is applied to patients 18 years old and older diagnosed with primary open-angle glaucoma who have had an optic nerve evaluation at least once within the past 12 months. This measure should be reported at least once within the reporting period.

Numerator: 2027F
Denominator: 18 years or older
ICD-9: 365.01, 365.10, 365.11, 365.12, 365.15
CPT-1: 92002, 92004, 92012, 92014, 99201-99205, 99212-99215, 99241-99245, 99304-99310, 99324-99328, 99334-99337*
Modifiers:
1P: Optic nerve head evaluation not performed for documented medical reasons
* 3P: Optic nerve head evaluation not performed for system reason (provider is not primarily responsible for glaucoma management)
8P: Optic nerve head evaluation not performed, reason not otherwise specified

*Denotes a new edit to the measure

If a patient was seen prior to the reporting period for an optic nerve evaluation and returns for an IOP check during the reporting period but an optic nerve evaluation is not performed at that visit, the measure is still reported because the guidelines state "optic nerve evaluation at least once with 12 months."

Thus, the measure should be reported or the encounter will count against the reporting totals as a missed reporting opportunity. Please note that the practitioner may be required to report this measure more than once within the reporting period because the reporting period covers an entire 12 months.

Measure #14: 2019F
ARMD - Dilated Macular Examination

This measure applies to patients 50 years old and older diagnosed with age related macular degeneration (ARMD) who have had a dilated macular examination performed at least once within the past 12 months. Documentation must include the presence or absence of macular thickening or hemorrhage AND the level of severity of the ARMD.

Numerator: 2019F
Denominator: 50 years or older
ICD-9: 362.50 362.51 362.52
CPT-1: 92002, 92004, 92012, 92014, 99201-99205, 99212-99215, 99241-99245, 99304-99310, 99324-99328, 99334-99337*
Modifiers:
1P: Medical reason(s) for not performing a dilated macular examination
2P: Patient reason for not performing a dilated macular examination
* 3P: Optic nerve head evaluation not performed for system reason (provider is not primarily responsible for ARMD management)
8P: Other reasons for not performing a dilated macular examination

*Denotes a new edit to the measure

Measure #18: 2021F
Diabetic Retinopathy Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

This measure applies to patients 18 years or older who have the diagnosis of diabetic retinopathy who have had a dilated macular or fundus examination at least once within the last 12 months. The documentation must indicate the presence or absence of macular edema AND the level of severity of the diabetic retinopathy.

The classification guidelines for the levels of diabetic retinopathy are well documented. The summary of this classification is posted at *www.aoa.org/x7990.xml.* Please note that the correct use for the diabetic ICD-9 codes require that diabetic retinopathy (362 .01-362 .06) must be coded if you are going to code 362 .07 for macular edema. Also note this measure is not used for diabetes *without* retinopathy.

Numerator: 2021F
Denominator: 18 years or older
ICD-9: 362.01, 362.02, 362.03, 362.04, 362.05, 362.06
CPT-1: 92002, 92004, 92012, 92014, 99201-99205, 99212-99215, 99241-99245, 99304-99310, 99324-99328, 99334-99337*
Modifiers:
1P: Documentation of medical reason dilated macular/fundus exam not performed
2P: Documentation of patient reasons dilated macular/fundus exam not performed
*3P: Documentation of system reason for exclusion when the provider is not primarily responsible for the management of the retinopathy
8P: Documentation of other reasons dilated macular/fundus exam not performed

*Denotes a new edit to the measure

Measure #19: 5010F, G8397, G8398
Diabetic Retinopathy Communication with Physician Managing Ongoing Diabetes Care

*Reported with the following G code and no longer reported with 2021F
G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy
OR reported with the following G code by itself (without 5010F)
G8398: Dilated macular or fundus exam not performed

This measure applies to patients 18 years or older who have the diagnosis of diabetic retinopathy who have had a dilated macular or fundus examination at least once within the last 12 months with documented communication with the physician who is managing the patient's diabetes.

Communication is defined as follows: Documentation in the medical record indicating that the results of the dilated macular or fundus exam were communicated (e.g., verbally, by letter) to the clinician managing the patient's diabetic care OR a copy of a letter in the medical record to the clinician managing the patient's diabetic care outlining the findings of the dilated macular or fundus exam.

Numerator: 5010F (without without a modifier) AND G8397 or G8398
Denominator: All patients with diabetic retinopathy
ICD-9: 362.01, 362.02, 362.03, 362.04, 362.05, 362.06
CPT-1: 92002, 92004, 92012, 92014, 99201-99205, 99212 – 99215, 99241-99245, 99304-99310, 99324-99328, 99334-99337*
Modifiers:
2P: Documentation of patient reasons for not communicating results to physician

See Quality, page 13

Quality

from page 12

*3P: Documentation of system reason for exclusion when the provider is not primarily responsible for the management of the retinopathy
8P: Documentation of other reasons for not communicating results to physician

*Modifier 1P has been eliminated from this measure

The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.
5010F and G8397: DR communication occurred and dilated macular or fundus exam performed
G8398: DR communication occurred and no dilated macular or fundus exam performed
5010F 2P and G8397: No DR communication occurred due to patient reasons but dilated macular or fundus exam performed
5010F 3P and G8397: No DR communication occurred due to system reasons but dilated macular or fundus exam performed
5010F 8P and G8397: No DR communication occurred due to unspecified reasons but dilated macular or fundus exam performed

Therefore, reporting on diabetic retinopathy might include up to three measures for each claim:

For example, when using 92004 with a diagnosis of 362.04, the practitioner might also report 2021F, 5010F and G8397 if the dilated retinal exam was performed, diabetic retinopathy was found, and the findings were communicated to the primary care physician responsible for caring for the diabetes.

*Denotes a new edit to the measure

Other measures potentially available for use by optometrists

Please note that the measures 114, 115, and 129 do not list the 92002-92014 series of codes as denominators at the time this article was written. The measures included here do list the 99201-99215 series of evaluation and management codes so they are available for those optometrists who can and do utilize the 99 codes series for some of their patient encounters. Measures 117, 124, 125, 128 do specifically list the 92 code series.

Measure #114: 1000F and 1034F or 1035F or 1036F
Inquiry Regarding Tobacco Use

This measure applies to patients 18 years or older who smoke and are queried about their tobacco use at least once within the past 24 months. This measure requires two CPT II codes per submission.
Numerator: 1000F: Tobacco use assessed
And one of the following:
1034F: Current tobacco smoker
1035F: Current smokeless tobacco user
1036F: Current tobacco non-user
Denominator: 18 years or older
99201- 99205, 99212-99215
Not associated with any specific ICD-9 diagnosis code
Modifiers:
8P: Tobacco used not assessed, reason not specified
Attach to 1000F, only this CPT II required to be reported when use not assessed.

Measure #115: G8402, G8403, G8455, G8456, G8457
Advising Smokers to Quit
(No CPT II codes available for use with this measure).

This measure applies to patients age 18 years and older who smoke and who received advice to quit smoking. If smoker, must file with two appropriate G codes.
Numerator:
G8402: Tobacco (smoker) use cessation intervention, counseling OR G8403 Tobacco (smoker) use cessation intervention not counseled AND G8455 Current tobacco smoker OR G8456 Current smokeless tobacco user OR G8457 Tobacco non-user
Denominator: 18 years or older
CPT-1: 99201 – 99205, 99212 – 99215, 99217- 99220, 99242-99245

Measure #117: 2022F, 2024F, 2026F, 3072F
Dilated Eye Exam in Diabetic Patient

This measure is used to report patients age 18 through 75 years with a diagnosis of diabetes mellitus who had a dilated eye exam and is used a minimum of once within 12 months.
Numerator:
2022F: Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed
2024F: Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed
2026F: Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed
3072F: Low risk for retinopathy (no evidence of retinopathy in the prior year)
Denominator: 18 to 75 years old

ICD-9: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04

CPT I: 92002, 92004, 92012, 92014, 99201-99205. 99212 – 99215, 99217-99220, 99242-99245, 99455-99456
Modifiers:
8P Dilated eye exam was not performed, reason not otherwise specified. 8P modifier does not apply to code 3072F.

Measure #124: G8447, G8448, G8449
HIT - Adoption/Use of Health Information Technology (Electronic Health Records)

This measure is to be reported at each visit occurring during the reporting period for patients 18 years and older seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by clinicians who have adopted and are using health information technology.

Patient encounter documentation substantiates use of certified/qualified EMR (CCHIT) or the EMR is non-certified but is capable of generating a medication list, a problem list and entering laboratory tests as discrete searchable data elements. To date, there are no commercially available, optometry-specific EMRs that have obtained certification.

Note that this measure cannot be used if the practitioner does not have an EMR that meets the qualifications listed above.

See Quality, page 14

PQRI poll

The AOA Washington Office is conducting a survey to determine how many optometrists are participating in Medicare's Physician Quality Reporting Initiative (PQRI).

AOA members are urged to respond by answering the following question:
Are you participating in the PQRI program to report quality indicators for eye care services?

YES, and I plan to do so in '08
YES, but I will not do so in '08
NO, but I plan to do so in '08
NO, and I do not plan to do so in '08

To participate in the poll, log on to the AOA Web site PQRI page (*www.aoa.org/pqri.xml*).

Quality

from page 13

Numerator:
G8447 Patient encounter was documented using a CCHIT Certified or Qualified EMR
G8448: Patient encounter was documented using a non-CCHIT certified EMR but the system was qualified (see above)
G8449: Patient encounter was not documented using an EMR due to system reasons but a certified or non-certified but qualified EMR is in place and generally available
Denominator: 18 years or older
CPT-1: 90801 – 90809, 92002 – 92014, 96150 – 96152, 97001-97004, 9750, 97802 – 97804, 98940 – 98942, 99201-99215, 99241-99245, D7140, D7210, G0101, G0108, G0109, G0270, G0271
Modifiers: None listed

Measure #125: G8443, G8445, G8446
HIT - Adoption/Use of e-Prescribing

This measure is to be reported at each visit occurring during the reporting period for patients 18 years and older seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by clinicians who have adopted a qualified e-Prescribing system.

A qualified e-prescribing system has been adopted capable of generating a medication list and selecting/printing/transmitting/performing safety checks of prescriptions. (Please see the specific CMS guidance for more details.)

Please note that this measure cannot be used if the practitioner does not have access to a qualified e-prescribing system.
Numerator:
G8443: All prescriptions created during the encounter were generated using a qualified e-Prescribing system
G8445: No prescriptions were generated during the encounter, provider does have access to a qualified e-Prescribing system
G8446: Some or all prescriptions generated during encounter were handwritten or phoned in due to a state law requirement, patient request, or qualified e-prescribing system was temporarily inoperable.
Denominator: 18 years or older
CPT-1: 90801-90809, 92002-92014, 96150-96152, 97001-97004, 9750, 97802-97804, 98940-98942, 99201-99215, 99241-99245, G0101, G0108, G0109
Modifiers: None listed

Measure #128: G8417, G8418, G8419, G8420, G8421, G8422
Universal Weight Screening and Follow-Up

This measure is used to report patients age 65 years and older with a calculated Body Mass Index (BMI) within the past six months or during the current visit that is documented in the medical record, and if the most recent BMI is greater than 30 or less than 22, a follow-up plan is documented.

BMI is a number calculated from a person's weight and height. BMI can be calculated using a chart or formula; however, the patient's actual weight and height must be measured and cannot be merely reported by the patient. Follow up can include documentation of a future appointment, education, referral, prescription/administration of medication/diet supplements and the like.
Numerators: G8417: BMI greater than 30 was calculated and a follow-up plan was documented in the medical record
G8418: BMI less than 22 was calculated and a follow-up plan was documented in the medical record
G8419: BMI greater than 30 OR less than 22 was calculated, but no follow-up plan documented in the medical record
G8420: BMI greater than 30 AND less than 22 was calculated and documented
G8421: BMI not calculated
G8422: Patient not eligible for BMI calculation or BMI not performed and/or Calculated BMI greater than 30 or less than 22, follow-up plan not documented, reason not specified in medical record
Denominator: Age 65 and older
ICD-9: 00140, 00142, 00170, 00400, 00402, 00810, 00832, 00851, 00910, 00920, 01380, 01382, 01400, 01732, 01810, 01820, 01829,
CPT-1 90801- 90809, 92002- 92014, 97001, 97003, 97802, 97803, 99201- 99215, 99241-99245, 99324 - 99328, 99334 - 99337, 99341- 99345, 99347 - 99350, D7140, D7210, G0101, G0108, G0270
Modifiers: None listed
Exceptions: Patients can be considered not eligible in the following situations: Patient already is diagnosed as over- or under-weight and there is documentation in the medical record that the weight problem is being managed by another provider; patient has a terminal illness; patient refuses BMI measurement; there is any other reason documented by the provider in the medical record, explaining why the BMI measurement was not appropriate; patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status

Measure #129: G8423, G8424, G8425, G8426
Universal Influenza Vaccine Screening and Counseling

This measure is to be reported at each visit occurring during the months of January, February, March, October, November, and December during the reporting period for patients seen during the reporting period and who are screened and counseled about influenza vaccine. This measure is used for patients age 50 years and older.
Numerator:
G8423: Documented that patient was screened and either influenza vaccination status is current or patient was counseled
G8424: Influenza vaccine status was not screened
G8425: Influenza vaccine status screened, patient status not current and counseling was not provided
G8426: Documented that patient was not appropriate for screening and/or counseling about the influenza vaccine (e.g., allergy to eggs)
Denominator: Age 50 and older
CPT: 00140, 00142, 00170, 00400, 00402, 00810, 00832, 00851, 00910, 00920, 01380, 01382, 01400, 01732, 01810, 01820, 01829, 90801- 90809, 97802, 97803, 99201- 99215, 99241-99245, 99324 - 99328, 99334 - 99337, 99341- 99345, 99347 - 99350, G0101, G0108, G0270
Modifiers: None listed

Summary

The 2008 PQRI reporting period is Jan. 1, 2008, to Dec. 31, 2008.
There are 11 measures available for use by optometrists for this reporting period.
Four of the 2007 measures were carried over with minor modifications.
There are seven new measures available for use by optometrists.
Successful reporting requires reporting at least three measures in 80 percent of the reportable cases.
Many of the measures now use G codes instead of CPT II codes with modifiers.
The AOA Web site will list all the up-to-date information.
The 2008 bonus is approximately 1.5 percent of all allowable Medicare charges.
The 2007 PQRI reports should be available in June 2008.
Congress could decide to change all or part of this program as it considers options to fix the flawed SGR reimbursement formula.

Past AOA presidents remembered

Frantz: Noted educator, author

Former AOA President Don A. Frantz, O.D., died Dec. 3, 2007, at the age of 91.

He served as AOA president during the 1961-1962 program year.

Dr. Frantz was the charter chair of the AOA committee on practice management. He served eight years as secretary of the AOA council on optometric education and served as chair of the Long-Term Planning Committee. He served as vice president of the Illinois Optometric Association (IOA) and was in charge of public information.

The IOA named Dr. Frantz the Optometrist of the Year in 1962.

Dr. Frantz graduated from the Northern Illinois School of Optometry in 1937.

After graduation, Dr. Frantz practiced in DeKalb, Ill., for 40 years.

He also taught practice management at the Illinois College of Optometry and was named to a Health, Education and Welfare commission under President Nixon.

Dr. Frantz wrote numerous articles on practice management, vision training, television vision, home lighting, and other optometric subjects. He was a distinguished member and lecturer for the Optometric Extension Program and was a fellow of the American Academy of Optometry and a past president of the Illinois chapter of the Academy.

As a pioneer in developing natural stereoscopic refraction techniques, Dr. Frantz produced the

Kodachrome slide series used by the AOA.

He was also active in Rotary clubs in Illinois and Florida.

Dr. Frantz is survived by his wife, Alta; two daughters, Pam (husband Doug) Schnetzler, and Carol (husband Dave) Oberg; five grandchildren; six great-grandchildren; and a brother, Charles Frantz.

Hussey served AOA 32 years

Former AOA President Lester Hussey, O.D., died on Dec. 21. He was the only member of the Optometric Physicians of Washington (then the Washington Optometric Association) to serve as president of the AOA.

Dr. Hussey served as AOA president during the 1970-1971 program year.

He served the AOA for 32 years, including service on the AOA's Insurance Committee, in the AOA Department of Public Health, and in the AOA Department of Organization.

He was president of the Washington Optometric Association (WOA) from 1958 to 1960.

The WOA named him the Optometrist of the Year in 1960.

Dr. Hussey graduated from the Los Angeles College of Optometry in 1938. His work included the areas of vision and reading and subnormal vision.

He interrupted his practice in Spokane, Wash., to serve in the Navy for four years beginning in 1943.

After returning to practice, Dr. Hussey served as president of the Spokane Rehabilitation Center, as the chair of the Spokane Employ the Handicapped Committee, and as president of the Eastern Washington Society for Crippled Children and Adults.

He also worked with the Spokane Central Lions Club and the Easter Seal Society.

Dr. Hussey was a board member of the Vision Institute of America and the Vision Conservation Institute of the Northwest.

Dr. Hussey is survived by his wife, Margaret, and two sons, Dana (wife Gail) Hussey and Eric (wife Lisa) Shaw Hussey. He had five grandchildren.

Contributions may be made to Liberty Park United Methodist Church, 1526 E. 11th, Spokane, WA 99202 or the Union Gospel Mission, PO Box 4066, Spokane, WA 99202.

COVD honors ODs, elects officers

The 37th Annual Meeting of the College of Optometrists in Vision Development in St. Petersburg, Fla., was attended by 610 people, setting a new attendance record.

For the two days prior to the meeting, intensive courses were given in the areas of visual information acquisition, visual information processing, strabismus and amblyopia, and acquired brain injury. In addition, a one-day "VT 101" course was presented for vision therapists.

COVD's President's Award was presented to Linda Sanet, from Lemon Grove, Calif., in recognition of her significant contributions to teaching and mentoring vision therapists.

The Optometry & Vision Development Award for best published article during the past year was given to Yi Pang, O.D., Ph.D., of the Illinois College of Optometry for his article "Myopia: Can Its Progression Be Controlled?" Additional authors on this article were Dominick Maino, O.D., MEd; Guoming Zhang, M.D., Ph.D.; and Fan Lu, O.D., M.D.

Harold Solan, O.D., of Cliffside Park, N.J., received the 2007 G.N. Getman Award in recognition of his clinical expertise in developmental optometry and his dedication to patient care. The 2007 A.M. Skeffington Award for outstanding contributions to the optometric literature in the areas of behavioral vision care and vision therapy was given to Kenneth Ciuffreda, O.D., Ph.D. The 2007 Certified Optometric Vision Therapist of the Year Award was given to Lyna Dyson of Poway, Calif., for her outstanding dedication to behavioral optometry and patient care.

Fourteen optometrists at the meeting became Board Certified Fellows (FCOVD) of COVD, while four became Board Certified Academic Fellows (FCOVD-A). These were added to four optometrists who became Board Certified Fellows (FCOVD) in Mexico a month earlier.

COVD elected Dan L. Fortenbacher, O.D., as president. Also serving during the coming year are: President-elect Bradley E. Habermehl, O.D.,; Vice President Carole L. Hong, O.D.; Secretary-Treasurer Robert S. Byne, O.D.; Immediate Past President Drusilla H. Grant, O.D.; East Regional Director Ida Chung, O.D.; Central Regional Director David A. Damari, O.D.; West Regional Director Julie B. Ryan, O.D.; Regional Director-at-Large Jason Clopton, O.D.

Call for posters open

The AOA is inviting participation in the Clinical and Scientific Poster Session at the 111th Annual AOA Congress & 38th Annual AOSA Conference: Optometry's Meeting™. The poster preview session will be held Friday, June 27, and the interactive session offering continuing education credit will be Saturday, June 28, from 11 a.m. to 2 p.m. at the Washington State Convention and Trade Center. Poster abstracts must be submitted electronically by Feb. 6, 2008. For details and an electronic submission form, log on to *www.optometrysmeeting.org* and click on the Call for Posters icon. For more information, contact Stacy Smith at 314-983-4254 or at *sasmith@aoa.org*.

Certification,

from page 1

quality assurance standards, and patients themselves who are growing to expect "score cards" for providers are all driving the trend toward performance assessment and credentialing.

"Pay-for-Performance may intensify the need for board certification for optometrists," Dr. Brooks said. "Optometry is a profession where certification and maintenance of certification could be important, but there is no mechanism yet for applying it."

The trend toward board certification and maintenance of certification is accelerating. Of practicing physicians in the United States, more than 85 percent are board certified, up from 50 percent in the 1960s.

In 2006, the American Board of Medical Specialties' 24 member boards adopted a program of continuous professional development—ABMS Maintenance of Certification —as a formal means of measuring a physician's continued competence in his or her certified specialty.

"Board certification is not only important to hospitals. Insurers, health care organizations and even large employers not traditionally associated with health care are now interested in board certification as a measure of quality health care delivery," said AOA President Kevin L. Alexander, O.D., Ph.D.

Working definitions

The Joint Board Certification Project Team has unanimously agreed to these "working definitions."

Board Certification in Optometry
A voluntary process that establishes standards that denotes a doctor of optometry has exceeded the requirement(s) necessary for licensure. It provides the assurance that a doctor of optometry maintains the appropriate knowledge, skills, and experience needed to deliver quality patient care in optometry.

Advanced Competence in Optometry
The possession of knowledge, skills, and experience beyond the requirement(s) necessary for licensure.

Maintenance of Certification in Optometry
A formal means of measuring cumulative and ongoing qualifications to deliver quality patient care.

Continuing discussion

Within optometry, there is growing recognition that ODs should not only have the current skills to treat patients using the highest standards of care, but must be able to prove they have those skills.

Dr. Brooks noted that as far back as the 1960s, the profession has looked at ways of proving practitioner competence.

The issue came to the forefront seven years ago when the American Board of Optometric Practice (ABOP) was proposed and ultimately rejected. The AOA House of Delegates, in voting down funding for ABOP, called for the AOA to lead a profession-wide summit and study the issue of specialization and board certification. This summit was called the Summit on Board Certification and Continued Competency.

Following that summit's report to the AOA House of Delegates in June 2001, two subsequent project teams studied the issue of advanced competence, specialization and board certification.

The final report in 2005 of the second project team, the Advanced Clinical Competence Project Team, recommended that discussion in this area occur as part of the upcoming Optometry 2020 Summit.

Dr. Brooks noted that it was significant that other organizations at the Optometry 2020 Summit — including AAO, ARBO, ASCO and NBEO — selected specific futures relating to advanced competence and board certification in August 2006.

AOA representatives agreed to work with these organizations to explore these futures.

In addition, in May 2006, ARBO — at the National Optometric Continuing Education Conference — concluded that "renewed dialogue should be considered involving all stakeholders, organized by ARBO and AOA leadership, to reassess the continued competence and board certification topic."

It was in light of these developments that the AOA supported the formation of a joint project team with representatives appointed by key stakeholder organizations, Dr. Brooks said.

"It's important that the entire profession agree on one model," said Dr. Alexander. "The issue of advanced competence and credentialing shouldn't belong to just one optometric organization, and we clearly don't want an organization outside of optometry to take on that role."

"To me, the issue of pursuing board certification in optometry is very much like the profession's decision to pursue therapeutic pharmaceutical privileges in past decades," Dr. Brooks said.

"There were arguments that therapeutic practice would create different classes of practitioners and create obstacles to ODs. There are similar arguments now against board certification, but I would contend that, just as gaining the ability to manage and treat patients with eye disease has improved our profession, being able to demonstrate, through board certification, a level of advanced clinical competence will open new doors to optometrists – and is the right thing to do."

I would contend that, just as gaining the ability to manage and treat patients with eye disease has improved our profession, being able to demonstrate, through board certification, a level of advanced clinical competence will open new doors to optometrists – and is the right thing to do."

The Joint Project Team has agreed that board certification must be credible, yet attainable for the practicing OD and needs to be a voluntary process not tied to licensure.

Dr. Brooks also said that the project team is looking at board certification as well as maintenance of certification in optometry and does not anticipate a sub-specialty component at this time.

Consensus so far

At a November meeting, the Joint Board Certification Project Team agreed to "Develop and propose an attainable, credible, and defensible model for Board Certification in Optometry and maintenance of certification for adoption by the profession. This model will establish standards for voluntary board certification and maintenance of certification in the practice of optometry. This model will communicate information about these standards to support the public's quest for safe high-quality health care."

Dr. Brooks noted that as the group continues to gather more information about board certification in other health care professions, it will continue to weigh the goals for the profession as outlined in the Optometry 2020 Summits.

To date, the Joint Board Certification Project Team has studied more than 3,000 pages of background material.

He explained that while the joint project team is charged with creating a model board certification process rather than a final product, the group will neither become a credentialing organization nor make a decision on whether such a process goes forward.

"I think board certification represents another step in the maturation of optometry as a profession," Dr. Brooks said.

"It's gratifying to see representatives of six diverse organizations working together toward a goal that will benefit the optometrist, the profession as a whole and ultimately our patients. We promise an open and transparent process with regular communications to keep the profession informed as we develop a process to advance the profession," he said.

Optometry's MEETING™

June 25 - 29, 2008

Reaching New Heights

For the first time, Seattle is hosting Optometry's Meeting™. Seattle describes itself as "Metronatural." What is metronatural?

Met•ro•nat•u•ral \ˌmə-trō-ˈna-chə-rəl\ – *adj.*

1 : having the characteristics of a world-class metropolis within wild, beautiful natural surroundings 2 : A blending of clear skies and expansive water with a fast paced city life - n. 3 : one who respects the environment and lives a balanced lifestyle of urban and natural experiences 4 : Seattle

Courtesy of the Seattle CVB

Seattle

Registration and Housing available in early February online at www.optometrysmeeting.org

See you in Seattle!

President

from page 3

have a way to demonstrate continued competence such as board certification.

There are many other concerns that optometric leaders have about the need to develop a means to demonstrate continued competence.

As AOA president, I understand the concern about adopting a program such as board certification. In subsequent President's columns, I intend to explore many of these concerns.

I believe the need to develop board certification as a means to demonstrate continued competence is very real. I ask for patience by the profession as we explore this issue thoughtfully, deliberately, slowly and with the input of many. I ask everyone to remain open to the idea that these six organizations are exploring board certification not to "create a new hoop to jump through" as has been suggested by some, but rather to proactively prepare the profession for the kind of scrutiny we are going to receive in the near future and to do it on our terms.

We do not want an organization outside optometry developing a way for us to demonstrate continued competence.

Like the scouting report of the old wagon trains, I know that many of you don't like the report your optometric scouts are giving you about the future. Some of you have asked—"Don't you know that if you polled optometrists you would find that they don't want board certification?" Of course, the answer to that question is obvious—no one wants to have additional requirements for continued practice.

But what if we asked your patients—"Do you think your optometrist should demonstrate competence on a regular basis?" I'll bet we'd get a different answer.

Kevin L. Alexander OD, PhD

"We do not want an organization outside optometry developing a way for us to demonstrate continued competence."

Call for Applications VSP Research Grants

The American Optometric Foundation (AOF) and VSP have entered into a partnership to support research into the efficacy of optometric care and optometric medical interventions.

Topics related to private practice and optometric outcomes will be given high priority. Examples would include diabetes, diabetic retinopathy, hypertensive retinopathy, glaucoma, corneal arcus, metabolic syndrome, and macular degeneration, but proposals in other areas are encouraged as well.

Other areas of emphasis include research investigating the possible links between optometry and other medical maladies and linkage to lifestyle and behavioral issues (like obesity) that have medical or optometric ramifications.

There will be a single one-year award of up to $42,000. A wide variety of research-oriented entities are eligible for this program, including but not limited to individual researchers; corporations; schools and colleges of optometry; schools and colleges of public health; schools and colleges of medicine; professional associations; and private foundations.

Submissions must be received by March 1, 2008. Grant recipients will be announced in May 2008. Each proposal must be submitted electronically (pdf recommended) on 8.5" x 11" sized paper and must contain the following components:

- Introduction; background and significance; specific aims; preliminary studies; and study design and methods. These sections should total no more than five pages.
- References (maximum of one page)
- Budget and budget justification (maximum of one page)
- Biographical sketch(es) of principal and one co-investigator only (maximum of two pages for each investigator)

o Education/training; research and professional experience; honors and awards
o Publications (refereed) for the last three years and representative earlier

Applications that do not follow this outline may not be considered. Proposals are reviewed by a peer review committee established by the AAO's Research Committee. All proposals must be sent by e-mail to Alisa Moore (*AlisaM@aaoptom.org*).

The AOF is not to cover any overhead/indirect costs associated with VSP Research Grants or any other of our programs.

This policy applies uniformly to all award recipients. Funds support research conducted for a period of one year. Recipients must submit a report of their research findings to the AOF at the end of the award period and will be encouraged to submit a manuscript to *Optometry and Vision Science*.

For additional information, contact Mark Bullimore, MCOptom, Ph.D., president, AOF: 614-292-4724 or *bullimore.1@osu.edu*.

Getting in touch with the AOA

AOA's volunteer structure is supported by 96 staff. For more information on AOA's programs and services, you may contact the staff at the following numbers.

Accounts Payable
800-365-2219 x4248
Accounts Receivable
800-365-2219 x4239
Accreditation Council on Optometric Education
800-365-2219 x4246, x4262 or x4223
JLUrbeck@aoa.org
WJRedd@aoa.org
TAWirth@aoa.org
Address Changes
800-365-2219 x4112
(Leave message)
AddressChange@aoa.org
AOA News
800-365-2219 x4216
RAFoster@aoa.org
RFPieper@aoa.org
TLOverton@aoa.org
AOA Political Action Committee
703-837-1376
JLTrute@aoa.org
Aviation Vision
800-365-2219 x4244
JLWeaver@aoa.org
Anniversary Awards (Member Records)
800-365-2219 x4238
MemberServices@aoa.org
Career Guidance Materials
800-365-2219 x4260
SKMeyer@aoa.org
Children's Vision Topical Interest Group (TIG)
800-365-2219 x4225
SDBrown@aoa.org
Classified Advertising
212-633-3986
K.Spurlock@elsevier.com
Clinical Care Information
800-365-2219 x4245/x4244
JLWeaver@aoa.org
Clinical Practice Guidelines
800-365-2219 x4237/x4244
BTKowalczyk@aoa.org
Coding/billing questions
703-837-1344 or
SCDwyer@aoa.org
Commission on Paraoptometric Certification
800-365-2219 x4135, x4210
DMLeuschke@aoa.org
SAlderson@aoa.org
Communications Group
800-365-2219 x4212
SMWasserman@aoa.org
Community Health Centers
800-365-2219 x4244 or x4209
JLWeaver@aoa.org
Contact Lens and Cornea Section
800-365-2219 x4137
RRRisko@aoa.org
Continuing Education: Opt. CE-Other Assns.
800-365-2219 x4117
ILAMO@aoa.org
Contract Analysis Service
800-365-2219 x4151
DAArbogast@aoa.org
Credits-AOA CE
800-365-2219 x4256
Council on Research
800-365-2219 x4244 or x4209
JLWeaver@aoa.org
Diabetes Initiative - CMS
703-837-1346
KHipp@aoa.org
Endowment Fund
800-365-2219 x4237
BTKowalczyk@aoa.org
Environmental/ Occupational Vision
800-365-2219 x4244 or x4209
JLWeaver@aoa.org
Ethics and Values
800-365-2219 x4244
JLWeaver@aoa.org
Event Calendar
EventCalendar@aoa.org
Eye Care Benefits
EAOrtmann-Vincenzo@aoa.org
800-365-2219 x4234
Federal Government Relations Center
703-739-9200, x1371
JFHymes@aoa.org
Finance Center
Accounts Payable
800-365-2219 x4248
Accounts Receivable
800-365-2219 x4239
Geriatrics/Nursing Facility
800-365-2219 x4237
BTKowalczyk@aoa.org
Health Information Technology
703 837-1348
JCMitchell@aoa.org
Hospital Practice
800-365-2219 x4237
BTKowalczyk@aoa.org
Industry Relations
800-365-2219 x4133
RABrauns@aoa.org
Infants' & Children's Vision Coalition
800-365-2219, x4245
AESabo@aoa.org
InfantSEE®
800-365-2219 x4286
InfantSEE@aoa.org
Member Insurance Program
EAOrtmann-Vincenzo@aoa.org
800-365-2219 x4234
Keyperson Program
703- 837-1378
ADrollette@aoa.org
Legal Aspects of Practice
800-365-2219 x4236
EAOrtmann-Vincenzo@aoa.org
800-365-2219 x4234
LRPlunkett@aoa.org
800-365-2219 x4218
JMSerra@aoa.org
Library (ILAMO)
800-365-2219
Information and Loans
x4117, 4118, 4102, or 4104;
Calendar of Meetings x4117
ILAMO@aoa.org
Low Vision Rehabilitation Section
800-365-2219 x4225
SDBrown@aoa.org
Managed Care
EAOrtmann-Vincenzo@aoa.org
800-365-2219 x4234
Media Relations
800-365-2219 x4263
SLThomas@aoa.org
Medicare Coding
703-837-1344
SCDwyer@aoa.org
Medicare Policy
703-837-1346
KHipp@aoa.org
Member Records (AOA)
800-365-2219 x4131
MemberRecords@aoa.org
Member Services
800-365-2219 x4179
MemberServices@aoa.org
Memorials and Tributes (Book of Memory)
AOA Endowment Fund
800-365-2219 x4237
BTKowalczyk@aoa.org
Museum
800-365-2219 x4102
LJDraper@aoa.org
New Technology
800-365-2219 x4245
JLWeaver@aoa.org
Ophthalmic Standards
800-365-2219 x4244/x4245
JLWeaver@aoa.org
Optometric Leadership Institute
800-365-2219 x4110
LMBaumstark@aoa.org
Optometric Recognition Awards (ORA)
800-365-2219 x4258 or x4260
ora@aoa.org
Optometry: Journal of the AOA
412-749-2568
PBFreeman@aoa.org
Optometry's Meeting™
General information
800-365-2219 x4214
SMRebori@aoa.org
Education
800-365-2219 x4254
SASmith@aoa.org
Exhibits
800-365-2219 x4255
KERodrigue@aoa.org
Student Programs
800-365-2219 x4251
LLTeasdale@aoa.org
Optometry's Career Center® (OCC)
800-365-2219 x4107
OCC@aoa.org
Order Department
To Place An Order:
800-262-2210
Business Cards/Office Forms:
800-262-2210
JRPayne@aoa.org
Payment Inquiries:
800-365-2219 x4239
Paraoptometric Section
800-365-2219 x4222 or 4108
JVMurphy@aoa.org
PS@aoa.org
Pediatrics/Binocular Vision
800-365-2219 x4245
JLWeaver@aoa.org
Practice Assistance Program
800-365-2219 x4111
JLKoonce@aoa.org
Practice Management Resources
800-365-2219 x4107
DBKincaid@aoa.org
Practice Strategies
800-365-2219 x4267
RFPieper@aoa.org
Primary Care
800-365-2219 x4245/x4244
JLWeaver@aoa.org
Professional Relations
703-837-1346
KHipp@aoa.org
Public Health Issues
800-365-2219 x4244 or x4209
JLWeaver@aoa.org
Public Relations
800-365-2219 x4263
SLThomas@aoa.org
Refractive Surgery Topical Interest Group (TIG)
800-365-2219 x4225
SDBrown@aoa.org
Quality Assessment and Improvement, Pay For Performance
800-365-2219 x1348
JCMitchell@aoa.org
Save Your Vision Month
800-365-2219 x4263
SLThomas@aoa.org
Seal of Acceptance
800-365-2219 x4244/x4245
JLWeaver@aoa.org
Sports Vision Section
800-365-2219 x4208
BMossman@aoa.org
State Legislation/ State Licensure/ State Optometry Laws
800-365-2219 x4266
SLCooper@aoa.org
Student and Faculty Programs
800-365-2219 x4106
LWBergman@aoa.org

Surveys
800-365-2219 x4238
Memberservices@aoa.org
Telemedicine
703 837-1348
JCMitchell@aoa.org
Third Party Issues
EAOrtmann-Vincenzo@aoa.org
800-365-2219 x4234
Travel Reimbursement
800-365-2219 x4239
VISION USA
800-365-2219 x4261
VISIONUSA@aoa.org
Web Site Information
800-365-2219 x4219
GCWilton@aoa.org

Direct lines to the AOA:
A new phone system allows AOA members to reach AOA staff directly. For St. Louis staff, dial (314) 983-XXXX, where the four digits are the four-digit extension code listed.

For Washington, DC, office staff, dial (703) 837-XXXX, where the four digits are the last four digits listed.

Don't know where to start? Call Member Services at 800-365-2219 x4179

Help us serve you better.
When calling, if you leave a message be sure to include information on whether the number is for your home or office and from what time zone you are calling. Better, include information on the best time for AOA staff to return your call.

Advanced Medical Optics

Alcon

Allergan

Bausch & Lomb

CIBA Vision Corporation

CooperVision

Essilor of America

HOYA Vision Care

Johnson & Johnson Vision Care

Liberty Sport

Luxottica Group

Marchon Eyewear

Optos

TLC Vision Corporation

Transitions Optical

VSP Vision Care

VisionWeb

Industry Profile is a regular feature in AOA News allowing participants of the Ophthalmic Council to express themselves on issues and products they consider important to the members of the AOA.

Industry Profile: Advanced Medical Optics

Advanced Medical Optics (AMO) is focused on providing the full range of advanced refractive technologies and support to help eye care professionals deliver optimal vision and lifestyle experiences to patients of all ages.

AMO offers market-leading technologies for myopia, hyperopia, astigmatism, presbyopia, cataract, spherical aberration, contact lens care and corneal health, as well as proven educational and support programs that help eye care professionals master refractive technologies and grow their practices.

Over the past year, AMO fortified its Complete Refractive Solution strategy through the acquisitions of IntraLase Corp., the global leader in ophthalmic femtosecond laser technology, and WaveFront Sciences, Inc., a provider of proprietary wavefront diagnostic systems.

Consequently, AMO now offers refractive surgeons an unrivaled, state-of-the-art LASIK system, which has been approved by the National Aeronautics and Space Agency (NASA) for use on U.S. astronauts.

The company also launched several new products in 2007, including the WhiteStar Signature™ phacoemulsification system, Tecnis® 1-Piece and Multifocal Acrylic Intraocular Lenses (IOLs) (Europe), and Complete® Multi-Purpose Solution Easy Rub™ Formula.

Products in AMO's cataract/implant line include IOLs, phacoemulsification systems, viscoelastics, and related products used in ocular surgery.

AMO owns or has the rights to such product brands as ReZoom®, Tecnis®, Clariflex®, Sensar®, and Verisyse® IOLs, Sovereign®, Sovereign® Compact and WhiteStar Signature™ phacoemulsification systems with WhiteStar® technology, Healon® viscoelastics, and the Baerveldt® glaucoma shunt.

Products in the laser vision correction line include wavefront diagnostic devices, femtosecond lasers and associated patient interface devices, and excimer laser vision correction systems and treatment cards.

AMO brands in the laser vision correction business include Star S4 IR®, WaveScan Wavefront®, Advanced CustomVue™, IntraLase® and IntraLasik®.

Products in the contact lens care line include disinfecting solutions, enzymatic cleaners and lens rewetting drops.

Among the eye care product brands the company possesses are Complete®, Complete® Blink-N-Clean®, Consept®F, Consept® 1 Step, Oxysept® 1 Step, UltraCare®, Ultrazyme®, Total Care™ and blink™ branded products.

AMO is based in Santa Ana, Calif., and employs approximately 4,200 worldwide.

The company has operations in 24 countries and markets products in approximately 60 countries.

For more information, visit the company's Web site at *www.amo-inc.com*.

Industry Profile is a regular feature in AOA News allowing participants of the Ophthalmic Council to express themselves on issues and products they consider important to the members of the AOA.

Acuvue 2 Colours offers iMakeover on Web site

Acuvue® 2 Colours® now offers iMakeover™ for those who are considering changing their looks with a new eye color.

The virtual makeover tool allows contact lens patients to get a sneak peek at what they would look like with different colored contact lenses that enhance or change their natural eye color.

Visitors to *www.imakeover.acuvue.com* can use this virtual changing room for contact lenses by uploading their own photos and trying on different colored lenses.

With 10 color choices, users can find the shades that best match their unique features.

Colored contacts, like Acuvue 2 Colours, are suitable for everyday wear or for special occasions.

"Like color cosmetics, colored contact lenses are a fabulous tool for enhancing your beauty," said makeup artist Mally Roncal. "I use colored contacts as a beauty accessory. My celebrity clients wear colored contact lenses to change their look for films, red carpet events and photo shoots."

Roncal's beauty tips for enhancing eye color and a free trial pair certificate are available on the iMakeover Web site.

How it Works

To start the virtual experience, patients can upload a high-quality digital photo (iMakeover recommends JPEG files and a forward-facing photo taken without glasses or a flash).

They can then choose from various shades of Acuvue 2 Colours, which can be fit for light eyes or dark eyes even if they do not need vision correction.

After choosing a color, users can then adjust the size, position and eyelid fit of the lenses to match their eye shape in the photo.

Next, they can choose from one of 11 decorative frames to complete the picture.

The selected color will appear in a description at the bottom of the photo to save "try on" time at the optometrist's office.

Finally, users can save, download, and print their iMakeover photo and free trial pair certificate to take to their doctor who will determine if Acuvue® 2 Colours® Brand Contact Lenses are right for them.

Allergan gets FDA approval for new IOP-lowering drug

Allergan, Inc. announced the U.S. Food and Drug Administration's approval of Combigan™ 0.2%/ 0.5%, an alpha adrenergic receptor agonist with a beta adrenergic receptor inhibitor, for the reduction of elevated intraocular pressure (IOP) in patients with glaucoma or ocular hypertension who require adjunctive or replacement therapy due to inadequately controlled IOP.

Combigan contains brimonidine and timolol and is the newest addition to Allergan's glaucoma portfolio, which also includes Lumigan® 0.03% and Alphagan® P 0.1% and 0.15%.

"Combigan ophthalmic solution is a medication that provides well-documented safety and efficacy for patients with inadequately controlled IOP," said Scott Whitcup, M.D., Allergan's executive vice president, Research and Development. "The development of Combigan, which has included five key clinical studies, underscores Allergan's commitment to provide new treatment options for patients with glaucoma."

Combigan is a prescription eye drop that works to reduce elevated IOP.

"There is no cure for glaucoma; however, lowering elevated IOP can slow the progression of the disease and help prevent further vision loss," said E. Randy Craven, M.D., director of the Glaucoma Consultants of Colorado and associate clinical professor of Ophthalmology, University of Colorado School of Medicine. "Many patients require more than one medication to meet their target IOP. With Combigan, it is exciting to be able to offer patients two strong agents in one bottle."

For more information, visit *www.allergan.com*.

Panoptx launches new logo, models, technology

Panoptx Eyewear launched a new logo, along with new models and new technology, this month.

The "7Eye" by Panoptx logo features a stylized numeral 7 tied to a new brand "7Eye" with a renewed emphasis on Dysfunctional Tear Syndrome (DTS) treatment and servicing the independent dispensaries that care for people with DTS symptoms.

"The eye care practitioner who already is focused on Dysfunctional Tear Syndrome treatment knows that our eyewear is essential once a patient reaches stage four of Dysfunctional Tear Syndrome," said Jackson Hogen, vice president of marketing and research and design.

"Yet, our greatest value may be to patients whose symptoms are less severe. If patients start wearing 7Eye before they reach stage four, there's a good chance their eyes won't just feel better with our eyewear, they'll actually be better," said Hogen.

A complete line of 7Eye by Panoptx products for all categories will be released this January.

Most models will bear familiar names and fits to help retailers through the transition, including the Bora, Churada and Whirlwind models in the Seal Protection Factor (SPF) 100 collection, and the Taku, Zephyr, Vortex and Gale models in the SPF75 series.

SPF100 provides 100 percent protection with the patented Orbital Seal™ eyecup, and SPF75 delivers 75 percent coverage through an ethylene vinyl acetate (EVA) foam air dam.

Polarized, photochromic and color-enhancing lenses are available in any frame style and prices vary depending on lens choice.

"We wanted a name with instant recognition, a logo that would stand out, a domain name that people could spell, a name with youthful energy and attitude," said Bob Hall, Panoptx president and CEO.

"We found that combination with the logo and 7Eye brand. We want to be recognized as an eye health brand that helps consumers see all seven colors in the spectrum of visible light. By helping people see the world in all its colors, we help them do whatever they want better and in greater comfort," said Hall.

"The introduction of 7Eye is the beginning of a new platform for product development," continued Hall.

"We have new eyecup technology and new frame designs due to roll out in 2008 that will separate us once and for all from our legion of imitators. We are creating a solid foundation for brand expansion and sales growth, and with new styles and new technology in the pipeline, 7Eye will fuel that growth."

Shown is Panoptx style Churada.

Transitions Optical appoints Craig president, Elias CEO

Transitions Optical, Inc. named Brett Craig president, effective Jan. 1, 2008. Rick Elias, who previously served as president, assumed the role of chief executive officer (CEO).

In the role of president, Craig, who was previously acting as chief operating officer (COO), is responsible for Transitions' business strategies, including strengthening partnerships with Transitions' customers, to meet ongoing growth objectives.

"Obviously the role of president is one of great responsibility and great opportunity," said Elias.

"Throughout the past months as acting COO, Brett has built solid relationships with employees and partners alike, making his move to this role a natural one. As CEO, I will focus my efforts on aligning with key customers globally toward mutual, strategic growth," said Elias.

Craig was named COO in June 2006. He joined Transitions in July 1999 as managing director, Asia Pacific, and then moved to managing director, EMEA (Europe, Middle East, Africa), where he played a key role in positioning the EMEA businesses for continued growth.

"I look forward to the challenges that will come with my new role as president of Transitions, as well as the opportunities and successes that lie ahead for our company and our partners," said Craig.

Brett Craig, Transitions president

"I intend to support the products and programs that we have in place, while exploring new areas of innovation that will expand the application of our technology and the advancement of healthy sight," said Craig.

For more information about Transitions, visit *www.transitions.com* or contact Transitions Optical Customer Service at 800-848-1506.

MEETINGS

February

TBI/ABI (OEP CLINICAL CURRICULUM) OPTOMETRIC EXTENSION PROGRAM FOUNDATION Feb. 9-11, 2008
Baltimore, MD Theresa Krejci
800/447 0370
TheresaKrejciOEP@verizon.net
www.oep.org.

TEXAS OPTOMETRIC ASSOCIATION 2008 TOA ANNUAL CONVENTION
February 14-17, 2008
Renaissance Hotel Austin
Brigitte Kelly 512/707-2020
FAX: 512/326-8504
toabrigitte@austin.rr.com
www.texas.optometry.net

HEART OF AMERICA CONTACT LENS AND PRIMARY CARE CONGRESS Feb. 15-17, 2008
Hyatt Regency Crown Center Hotel, Kansas City, MO www.hoacls.org

OREGON OPTOMETRIC PHYSICIANS ASSOCIATION/ OPTOMETRIC PHYSICIANS OF WASHINGTON COLUMBIA OPTOMETRY CONFERENCE
Feb. 15-17, 2008
Vancouver Hilton, Vancouver, Washington Judy Balzer
425/455-0874 FAX: 425/646-9646 opw@eyes.org

DELAWARE OPTOMETRIC ASSOCIATION WINTER THAW CONTINUING EDUCATION EVENT Feb. 16, 2008
Embassy Suites, Newark, Delaware
Troy Raber, O.D. 302/346-1470
traberod@aol.com

SUNY, COLLEGE OF OPTOMETRY SKIVISION Feb. 16-20, 2008
Snow Mass, CO, 800/868-4888
www.skivision.com

AEA CRUISES OPTOMETRIC CRUISE SEMINAR – Southern Caribbean Explorer February 16-23, Aboard the Crown Princess®
888/638-6009
aeacruises@aol.com
www.optometriccruiseseminar.com

PRESIDENT'S WEEK 2008
Feb. 16-23, or Feb. 17-24,
Sunset Jamaica Grande Resort & Spa, Ocho Rios, Jamaica

TROPICAL CE BELIZE 2008
Feb. 16-23, 2008
Ramon's Village Resort & Sunbreeze Beach Hotel, 281/808-5763
sautry@tropicalce.com
www.tropicalce.com

THE PALM BEACH OPTOMETRIC ASSOCIATION PALM BEACH WINTER SEMINAR
February 22-24,2008
PGA Resort & Spa, Palm Beach Gardens, Florida
561/792-9110 www.pbcoa.org

ESSENTIALS OF BEHAVIORAL VISION CARE (OEP CLINICAL CURRICULUM) Optometric Extension Program Foundation
Feb. 23-24, 2008 Phoenix, AZ
Theresa Krejci 800/447 0370
TheresaKrejciOEP@verizon.net
www.oep.org

THE CODING INSTITUTE OPTOMETRY CODING & BILLING CONFERENCE February 24-26,
Bally's Las Vegas, Nevada
Lacy Keith 866/251-3060
www.codingconferences.com

AEA CRUISES OPTOMETRIC CRUISE SEMINAR
PANAMA CANAL
February 25-March 6, 2008
Aboard the Crown Princess®
888/638-6009
aeacruises@aol.com
www.optometriccruiseseminar.com

SECO INTERNATIONAL 2008
February 27-March 2, 2008
Georgia World Congress Center, Atlanta, GA www.seco2008.com

BIG SKY 2008 SKI CONFERENCE MONTANA OPTOMETRIC ASSOCIATION Feb. 28-March 1, 2008 Big Sky Ski Resort, Big Sky, Montana, Sue A. Weingartner
406/443-1160
FAX: 406/443-4614
suew@mteyes.com
www.mteyes.com

MAINE OPTOMETRIC ASSOCIATION
March "CE & SKI" Conference
Feb. 29-March 1, 2008, Grand Summit Hotel - Sugarloaf, Carrabassett Valley, ME
Joann Gagne, 207/626-9920
moa.office@maineeyedoctors.com
www.maineeyedoctors.com

March

NORTHWEST CONGRESS OF OPTOMETRY OPTOMETRIC EXTENSION PROGRAM FOUNDATION March 1-2, 2008
Pacific University, Forest Grove, OR
Eric Hussey
spacegoggle@comcast.net

SACRAMENTO VALLEY OPTOMETRIC SOCIETY 20TH ANNUAL OCULAR SYMPOSIUM
March 2, 2008
Marriott Sacramento Rancho Cordova Hotel, Rancho Cordova, California, Jerry Sue Hooper
916/447-0270
jerrysue@svos.info

22ND ANNUAL EYE SKI CONFERENCE March 2-8, 2008
Park City, Utah, Tim Kime, O.D.
419/475-6181
FAX: 419/475-5720
www.eyeskiutah.com

NORTH DAKOTA OPTOMETRIC ASSOCIATION 2008 CONTINUING EDUCATION/ FIGHTING SIOUX HOCKEY CONFERENCE March 6-8, 2008
Holiday Inn, Grand Forks, North Dakota, Nancy Kopp
701/258-6766
ndoa@btinet.net
www.ndeyecare.info

VT/VISUAL DYSFUNCTIONS (OEP CLINICAL CURRICULUM)
Optometric Extension Program Foundation, March 6-10, 2008
Baltimore, MD, Theresa Krejci
800/447 0370
TheresaKrejciOEP@verizon.net
www.oep.org.

ALLEGANY OPTICAL NATIONAL OPTOMETRY CONTINUING EDUCATION LECTURE SERIES VIII
March 9, 2008
Kepler Theater, Hagerstown Community College, Hagerstown, Maryland, Debbie Staley, BS
301/790-2800, ext. 454
staleyd@hagerstowncc.edu

GREAT LAKES CONGRESS OPTOMETRIC EXTENSION PROGRAM FOUNDATION
March 9-10, 2008
Renaissance North Shore Hotel, Northbrook, IL, John Loesch, O.D.
708/917-5353
drjohnod1@comcast.net

OPTOWEST 2008
March 13-16, 2008
Long Beach Convention Center, Long Beach, California
Tamalon Littlefield
800/877-5738, ext. 228
FAX: 916/448-1423
tamalon@coavision.org
www.optowest.com

MARYLAND OPTOMETRIC ASSOCIATION AND WILMER EYE OPTICAL/JOHNS HOPKINS EVIDENCE BASED CARE IN CONTACT LENS, GLAUCOMA AND CORNEA THERAPEUTICS
March 30, 2008
Turner Auditorium on the Johns Hopkins Hospital Campus, Baltimore, Maryland
Kristen Shoemaker
410/727-7800; 410/727-1801
FAX: 410/752-8295
moa@assnhqtrs.com
www.marylandeyes.com

FOUNDATIONS 1
(OEP Clinical Curriculum)
Optometric Extension Program Foundation, March 28-30, 2008
San Marcos, CA Theresa Krejci
800/447 0370
TheresaKrejciOEP@verizon.net
www.oep.org.

TROPICAL CE PUNTA CANA, D.R.
March 29-April 5, 2008
Paradisus Punta Cana – All-inclusive reserve suites
Stuart Autry, 281/808-5763
sautry@tropicalce.com
www.tropicalce.com

PENNSYLVANIA OPTOMETRIC ASSOCIATION
POA TECHNOLOGY CONFERENCE March 30, 2008
Sheraton Harrisburg-Hershey, Harrisburg, Pennsylvania
Ilene Sauerteig, 717/233-6455
ilene@poaeyes.org

April

NEW JERSEY ACADEMY OF OPTOMETRY GOLF CONFERENCE
April 2-6, 2008 Kingston Plantation, Myrtle Beach, SC, 732/920-0110
dhl2020@aol.com

VT/LEARNING RELATED VISUAL PROBLEMS (OEP CLINICAL CURRICULUM)
April 3-7, 2008 (Tentative)
Optometric Extension Program Foundation, co-sponsored by NOVA Southeastern University
Ft. Lauderdale, FL. Theresa Krejci
800/447 0370
TheresaKrejciOEP@verizon.net
www.oep.org

NORA
Optometric Extension Program Foundation
April 12-13, 2008
San Antonio, TX
www.nora.cc

PSS 2008: CONFERENCE ON COMPREHENSIVE EYECARE
April 12-13, 2008
Crowne Plaza Niagara Falls, NY
203/415-3087
education@psseyecare.com
www.psseyecare.com

THE OHIO STATE UNIVERSITY BINOCULAR VISION/PEDIATRICS AND CHILDREN'S LEARNING FORUMS
April 17-18, 2008
Columbus, Ohio
Marjean Taylor Kulp
614/688-3336
kulp.6@osu.edu
www.optometry.osu.edu

ARKANSAS OPTOMETRIC ASSOCIATION
SPRING CONVENTION
April 17-19, 2007
Embassy Suites, Little Rock, AR
Jennifer Martinez
501/661-7675
FAX: 501/372-0233
www.arkansasoptometric.org

ORTHOKERATOLOGY ACADEMY OF AMERICA & UNIVERSITY OF HOUSTON, COLLEGE OF OPTOMETRY
SECOND ANNUAL RESHAPING THE WORLD CONFERENCE
April 17-20, 2008
Westin San Diego, California
Cary M. Herzberg, O.D., FOAA
866/851-9922
www.okglobal.org

MISSOURI OPTOMETRIC ASSOCIATION
SPRING CE
April 17-22, 2008
St. Maarten
Joyce Baker
573/635-6151
info@moeyecare.org

UNIVERSITY OF CALIFORNIA, BERKELEY, SCHOOL OF OPTOMETRY 23RD ANNUAL MORGAN/SARVER SYMPOSIUM
April 18-20, 2008
DoubleTree Hotel, Berkeley Marina, Nyla Marnay
510/642-6547 or 800/827-2163
FAX: 510/642-0279
optoce@berkeley.edu
www.optometry.berkeley.edu

DADE COUNTY OPTOMETRIC ASSOCIATION
MIAMI NICE EDUCATION SYMPOSIUM
APRIL 19-20, 2008
WESTIN COLONNADE HOTEL, CORAL GABLES, FLORIDA
800/808-5018
FAX: 772/334-0856
DCOA@MIAMIEYES.ORG

KANSAS OPTOMETRIC ASSOCIATION
ANNUAL CONVENTION
April 24-26, 2008
Capital Plaza Hotel, Topeka, KS
info@kansasoptometric.org
www.kansasoptometric.org

MOUNTAIN WEST COUNCIL OF OPTOMETRISTS
MWCO ANNUAL CONGRESS
April 24-26, 2008
Bellagio Hotel, Las Vegas, Nevada
Tracy Abel
888/376-6926 or 503/436-0798
FAX: 503/436-0612
tracyabel@earthlink.net
www.mwco.org

106TH KOA ANNUAL SPRING CONGRESS
KENTUCKY OPTOMETRIC ASSOCIATION
April 24-27, 2008
Marriott Louisville Downtown Hotel, Louisville, Kentucky
sarah@kyeyes.org

VIRGINIA OPTOMETRIC ASSOCIATION
VOA VOYAGES IN VISION CE CONFERENCE
April 24-27, 2008
JW Marriott Cancun Resort, Cancun, Mexico
Bruce B. Keeney, Sr.
804/643-0309
www.voaeyedocs.org

THE SEAVISION CONFERENCE
April 24-May 3, 2008
Scotland & Ireland

To submit an item for the meetings calendar, send a note to eventcalendar@aoa.org

State University of New York
State College of Optometry

DIRECTOR PROFESSIONAL SERVICES/CHIEF OF STAFF

The State University of New York State College of Optometry invites nominations and applications for the position of Director of Professional Services/Chief of Staff. The Director of Professional Services assumes the overall clinical responsibility for the development of professional and clinical standards within the University Optometric Center (UOC) and for the implementation of these standards. Additionally, this individual will be involved in the following activities: assuring quality patient care, marketing, organization and patient flow, clinic staffing, clinic service collaboration, communication and budgeting.

The successful candidate must be an effective leader, working well with faculty and staff and must be an excellent communicator capable of mentoring clinical staff and integrating exciting and innovative changes into the clinical program. Candidates should have experience in administration with additional experience in clinical teaching, managed care, and/or clinical research. A Doctor of Optometry degree is required. The Director of Professional Services will report to the Vice of President of Clinical Affairs.

Applicants should submit a letter of interest, CV, and the names and complete contact information for three references. Confidential inquiries, nominations, and application materials should be directed to:

Richard Soden, OD, FAAO
VP for Clinical Affairs
SUNY College of Optometry
33 West 42nd Street,
New York, NY 10036

rsoden@sunyopt.edu
212-938-4036

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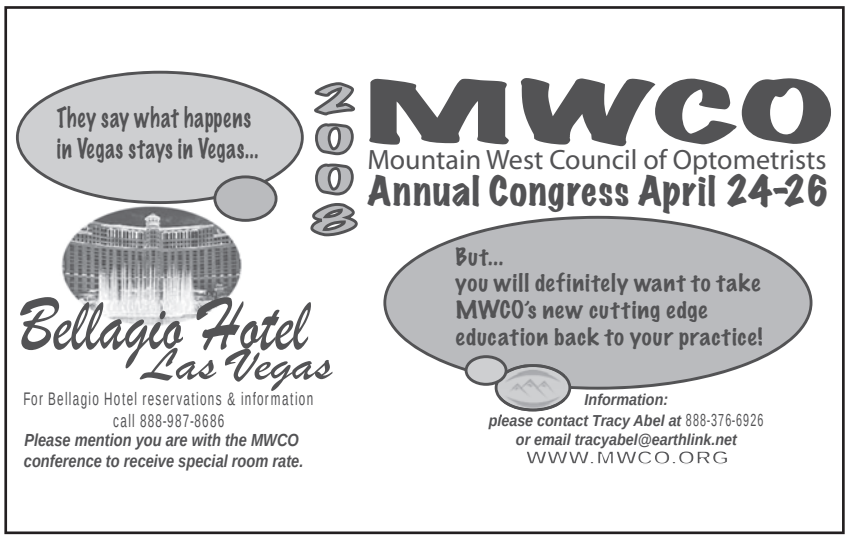
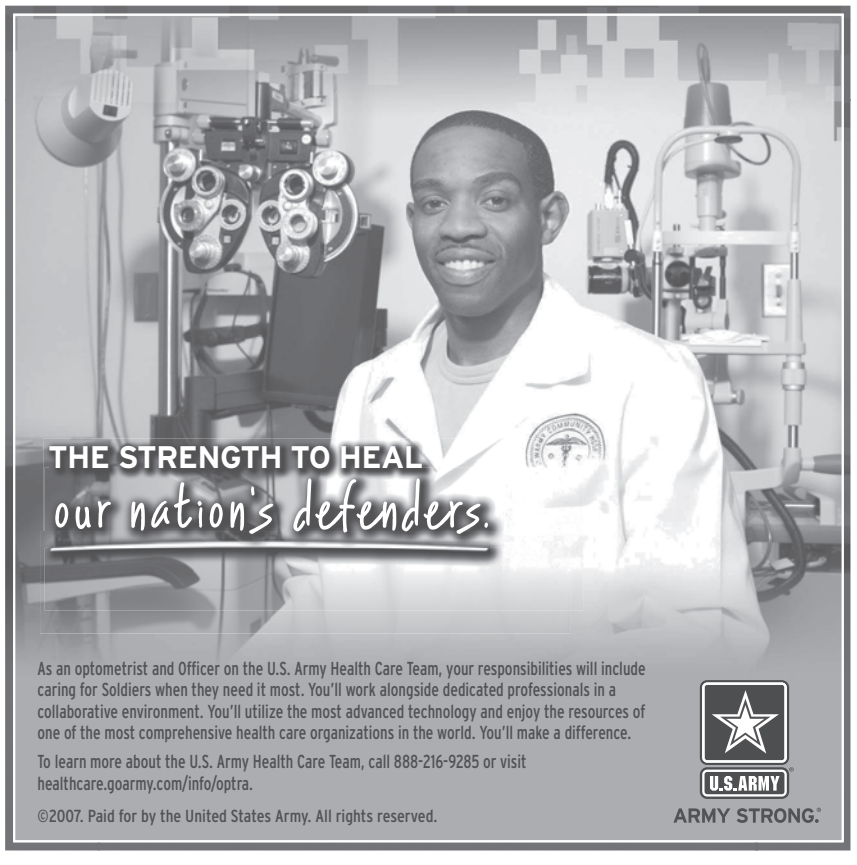


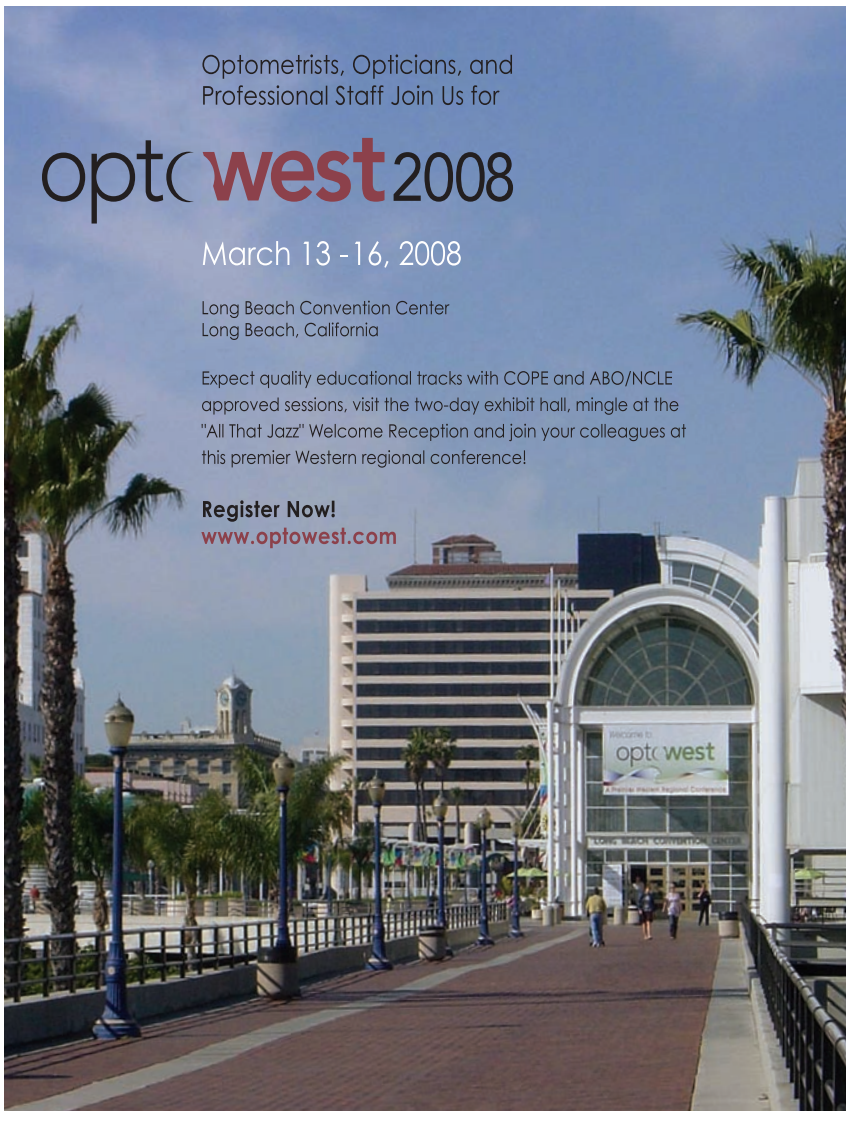
COLLEGE OF SYNTONIC OPTOMETRY

A Nonprofit Corporation Dedicated To Research in Photoretinogy
The Therapeutic Application of Light To The Visual System

76th International Conference on Light & Vision

Phoenix, Arizona
Dates: May 1-4, 2008
Embassy Suites Hotel
Phoenix – North
Contact: Ron Wahlmeier
Phone: (866)486-0190
e-mail: syntonics@bresnan.net
website: www.syntonicphototherapy.com





CORNEA AND LASER EYE INSTITUTE - OPTOMETRIST

The Cornea and Laser Eye Institute – Hersh Vision Group in Teaneck, New Jersey is seeking an optometrist with interest in refractive surgery patient management and specialty contact lens fitting.

The Cornea and Laser Eye Institute is a nationally recognized practice dedicated to clinical care, research, and teaching in corneal diseases and refractive surgery. With the complete range of corneal diagnostic tools and surgical instrumentation, the Cornea and Laser Eye Institute offers patients access to years of specialized experience, advanced technologies, and treatment alternatives, and offers the practitioner an opportunity to participate in and expand a unique subspecialty practice.

In addition to direct clinical care, CLEI participates in a number of nationwide clinical trials, including refractive surgery, device, drug, and contact lens studies. Complementing these efforts are active research programs in collaboration with UMDNJ-New Jersey Medical School and Princeton University.

We currently have an opening for a full-time optometrist. Candidates must have earned a Doctor of Optometry degree from an accredited college or school of optometry and possess a current New Jersey license. The position entails pre and postoperative care of refractive surgery patients (LASIK, PRK/LASEK, CK and Intacs), specialty contact lens fitting (postops, keratoconus), and clinical research opportunities. This is a unique subspecialty career position. Fellowship opportunities also considered. Some Saturdays and evenings required. Salary commensurate to training and experience.

Please send CV and letter of interest to:

Stacey Lazar, General Manager
slazar@vision-institute.com
info@vision-institute.com
Fax – 201-692-9646

New England Eye Institute Invites Applications for Professional Staff Appointments

The New England Eye Institute (NEEI), the clinical system of the New England College of Optometry (NECO), invites applications for professional staff members to serve as attending optometrists and clinician educators within NEEI's community health center network locations.

Our mission is to improve the visual health of populations through excellence in collaborative and community-oriented patient care, service, education, and research. A NEEI optometrist is a highly qualified doctor of optometry and clinician-educator who works within a dynamic team-oriented, multidisciplinary non-profit eye care network serving the visual health needs of populations in greater Boston. NEEI attending optometrists also receive adjunct teaching appointments with NECO and thus will have opportunity to advance both our service and teaching mission.

Network opportunities are now available at our community health center affiliates. Required qualifications include an OD degree, advanced professional credentials such as residency training or equivalent clinical experience, eligibility to be licensed in Massachusetts and an active commitment to excellence in patient care and teaching.

We offer a very competitive salary and benefit package. Start dates for these appointments will vary, ranging from March 1, 2008 – July 1, 2008. Applicants should submit a letter of application and curriculum vitae by February 1, 2008 to:

Roger Wilson, O.D. Vice President, Health Center Programs
New England Eye Institute
940 Commonwealth Avenue, Suite 2
Boston, MA 02215-1203
617.587.5511 ext. 5198
wilsonr@neco.edu
www.newenglandeye.org

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COLLEGE OF OPTOMETRY

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Chief of Pediatric Optometry / Chief of Neuro-Optometric Rehabilitation

The Western University of Health Sciences College of Optometry seeks two clinical faculty with special expertise in Pediatric Optometry and in Neuro-Optometric Rehabilitation. Successful candidates will have a history of achievement in patient care within their area of specialty and experience in optometric education. Essential functions include direct patient care, supervision of students and residents while providing patient care in the area of specialty, administration of the specialty service at the on-campus clinic, practice development and promotion, community service, supervising and mentoring faculty and staff, and lecturing. A track record of scholarly accomplishments and successful practice building are required. Demonstrated entrepreneurship and leadership abilities are highly desired. Faculty rank will be commensurate with experience. Salary and benefits are competitive. Requirements include the ability to obtain California licensure within one year of appointment.

Applicants should submit the following to Daniel Kurtz, PhD, OD, Associate Dean of Academic Affairs , Western University College of Optometry, 309 E. Second St., Pomona, CA 91766-1854 <dkurtz@westernu.edu>:

1. a current curriculum vitae
2. a cover letter explaining how the applicant's background meets the requirements of this position. This letter may include a brief statement including examples of teaching experience, philosophy, and goals. Please include your contact information.
3. a completed Employment Application found at http://www.westernu.edu/bin/hr/pdf/application_for_employment.pdf

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Please look through your garage, closets, basement for all your unused books, equipment, instruments, stock frames and lenses and any items that might be of use to a Optometry school, a student or eye clinic. Instructions on how to proceed are available by going to the VOSH website (www.vosh.org) and click on Technology Transfer Program. Information about IMEC is available at www.imecamerica.

The most desirable items that programs in developing countries need are: Trial lens kits, battery powered hand scopes, assorted pliers and optical tools, hand stones for edging glass lenses, uncut lenses (both SV and BF), manual lensometers, phoropters, lens clocks, color vision tests, keratometers and biomicroscopes.

This list is certainly not complete but gives an idea of some of the basic needs these developing programs can benefit from. All items may be shipped directly to:
VOSH INTERNATIONAL
C/O IMEC
1600 Osgood Street
North Andover, Mass. 01845

Assistance with shipping cost may be available through your local Rotary or Lions Clubs. Contact www.vosh.org with any questions or email jaforrey@comcast.net and voshinternational@comcast.net.

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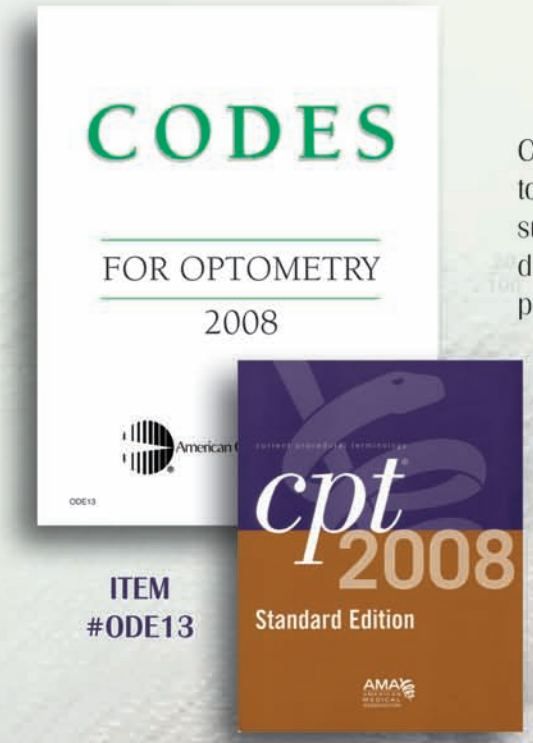

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